

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) William Harvey ADKINS						2a. DATE OF DEATH July 26, 1968			2b. HOUR AM 12:40		
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 10, 1902			6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel County, Md.				
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A. A. County Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during major working life, even if retired.) Ret.			12b. KIND OF BUSINESS OR INDUSTRY A.A. Co. Bd of		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Ed. 213th Street Green Haven		
14. FATHER'S NAME First Luctaion Middle Adkins Last Adkins				15. MOTHER'S MAIDEN NAME First Pollie Middle Vaughn Last Vaughn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service) None		16b. SOCIAL SECURITY NO. 236-09-9599A		17. INFORMANT Address Leonard N. Adkins (son) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma Neck + B2 med. A. yr. 159 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Ca Prob. G.I. system DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 158											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from April, 1968 to 7-26-1968 , that (I) (we) last saw the deceased alive on 7-25-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. J. Stephens				22c. DATE SIGNED 7-26-68				22d. PHYSICIAN'S NAME (Type) W. J. Stephens			
22e. ADDRESS Glen Burnie, Md.				22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22g. REC'D BY REGISTRAR <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.		23e. REC'D BY REGISTRAR Charles Judge			
24. FUNERAL DIRECTOR EBB Flanning		24a. ADDRESS Singleton Funeral Home		24b. CITY OR TOWN Glen Burnie, Md.		24c. DATE JUL 29 1968		24d. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all blank papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Edward NMN ALTON			2a. DATE OF DEATH Month July Day 10 Year 1968			2b. HOUR 9:15 M A				
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH Jan. 24, 1910		6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY ***	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 311 Chester Ave.,	
14. FATHER'S NAME First Middle Last Louis Wesley Alton			15. MOTHER'S MAIDEN NAME First Middle Last Georgie NMN Melden							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) *****			16b. SOCIAL SECURITY NO. 214-05-1041		17. INFORMANT Louis Alton		Address 924 Central St. Anna, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5-5- , 19 59 , to 7-10- , 19 68 , that (I) (we) last saw the deceased alive on 7-10- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A. T. Allen					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/10/68			
22d. PHYSICIAN'S NAME (Type) A. T. Allen, M.D.					22e. ADDRESS 62 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-13-1968		23c. NAME OF CEMETERY OR CREMATORY Hopes Chapel			23d. LOCATION (City or Town) (County) (State) A.A.Co. Md			
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Md					25a. REC'D BY REGISTRAR DATE JUL 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY: JAMES B. LEECH, PRINTERS

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NEW YORK: JAMES B. LEECH, PRINTERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 may be retained by the funeral director, and any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First: Anna Middle: Marie Last: ANDERSEN						2a. DATE OF DEATH Month: July Day: 30 Year: 1968			2b. HOUR P. 3:10 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 5, 1893		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Denmark		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First: Otto Middle: Wiberg Last: Wiberg				15. MOTHER'S MAIDEN NAME First: Louise Middle: (UNKNOWN) Last: (UNKNOWN)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Mrs. John Hubbard		Address Edgewater, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>HASLED</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 443X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>68</u> , to <u>7/30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert O. Biern				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/30/68			
22d. PHYSICIAN'S NAME (Type) Robert O. Biern, M.D.				22e. ADDRESS 121 Cathedral St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8/2/68		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City or Town) Newport News		(County) VA		(State)	
24. FUNERAL DIRECTOR Hardesty Funeral Home				ADDRESS Annapolis, Md		25a. REC'D BY REGISTRAR AUG 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
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CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Elnora Delmay ATWELL						2a. DATE OF DEATH Month Day Year July 23 1968		2b. HOUR P. 2:40 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 18, 1914		6. AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Ben. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 186 Woods Drive	
14. FATHER'S NAME First Middle Last CARL FERDINAND Wilde			15. MOTHER'S MAIDEN NAME First Middle Last MARGARET M. GUY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes, give year or dates of service)			16b. SOCIAL SECURITY NO. 213-22-0648		17. INFORMANT Clyde N. Atwell		Address ANNAPOLIS, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 5710 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC ALCOHOLISM DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS 10 YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5811										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan 1937 , to 23 July, 1968 , that (I) (we) last saw the deceased alive on 23 July 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edward S. Beck DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 7/24/68					
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.					22e. ADDRESS 73 Franklin St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/26/67		23c. NAME OF CEMETERY OR CREMATORY QUAKER CEMETERY		23d. LOCATION (City or Town) (County) (State) Galesville AA MD				
24. FUNERAL DIRECTOR HARDESTY FUNERAL HOME ADDRESS ANNAPOLIS, MD					25a. REC'D BY REGISTRAR JUL 25 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Robert Joseph Bancroft			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 7 Day 2 Year 68			2b. HOUR P			
3. SEX M	4. RACE W	5. DATE OF BIRTH 7-9-14	6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month 7 Day 2 Year 68			
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A.M.CU			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel - OOR		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Wireman		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last Robert Bancroft			15. MOTHER'S MAIDEN NAME First Middle Last Theresa Albert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 144-09-8888		17. INFORMANT ADDRESS Mrs. Doris M. Bancroft (wife) Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy generalized 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE E. L. W. Hancock			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) A.M.CU			22b. DATE SIGNED 7-2-68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 5, 1968		23c. NAME OF CEMETERY OR CREMATORY U.S. National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Singleton Funeral Home				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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09335

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09348

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <i>THOMAS</i>		First <i>THOMAS</i>		Middle <i>B</i>		Last <i>BARRELL</i>		2a DATE KNOWN OF DEATH Month <i>7</i> Day <i>15</i> Year <i>68</i>		2b HOUR <i>A</i> M	
3 SEX <i>M</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>10-9-1910</i>		6 AGE <i>57</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Blandon, Pa.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel Co.</i>					
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address) <i>Don-north. Arundel.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Truck Driver</i>		12b Kind of BUSINESS OR INDUSTRY <i>Hall's Motor</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Maryland</i>		13b COUNTY <i>Anne Arundel</i>		13c CITY OR TOWN <i>Glen Burnie</i>		13d INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>1410 Sundown Rd.(Ferndale)</i>			
14. FATHER'S NAME First <i>Henry</i> Middle <i>Barrell</i> Last <i>Barrell</i>		15. MOTHER'S MAIDEN NAME First <i>Cassiah</i> Middle <i>Fike</i> Last <i>Fike</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO <i>207 05 9307</i>		17. INFORMANT ADDRESS <i>Mrs. Hazel M. Barrell (wife) Same As #13</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic hypenditer.</i> <i>128X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>128X</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>400+</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>E. L. Howard</i>		EXAMINER'S NAME (Type) <i>E. L. Howard</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>7-11-68</i> <i>A.M. Co.</i>			
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b DATE <i>July 19, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Pleasant View Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Spring Township, Berk Co., Pa.</i>					
24 FUNERAL DIRECTOR <i>A. Singleton</i>		ADDRESS <i>SONGLETON FUNERAL HOME GLEN BURNIE, MARYLAND</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 17 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

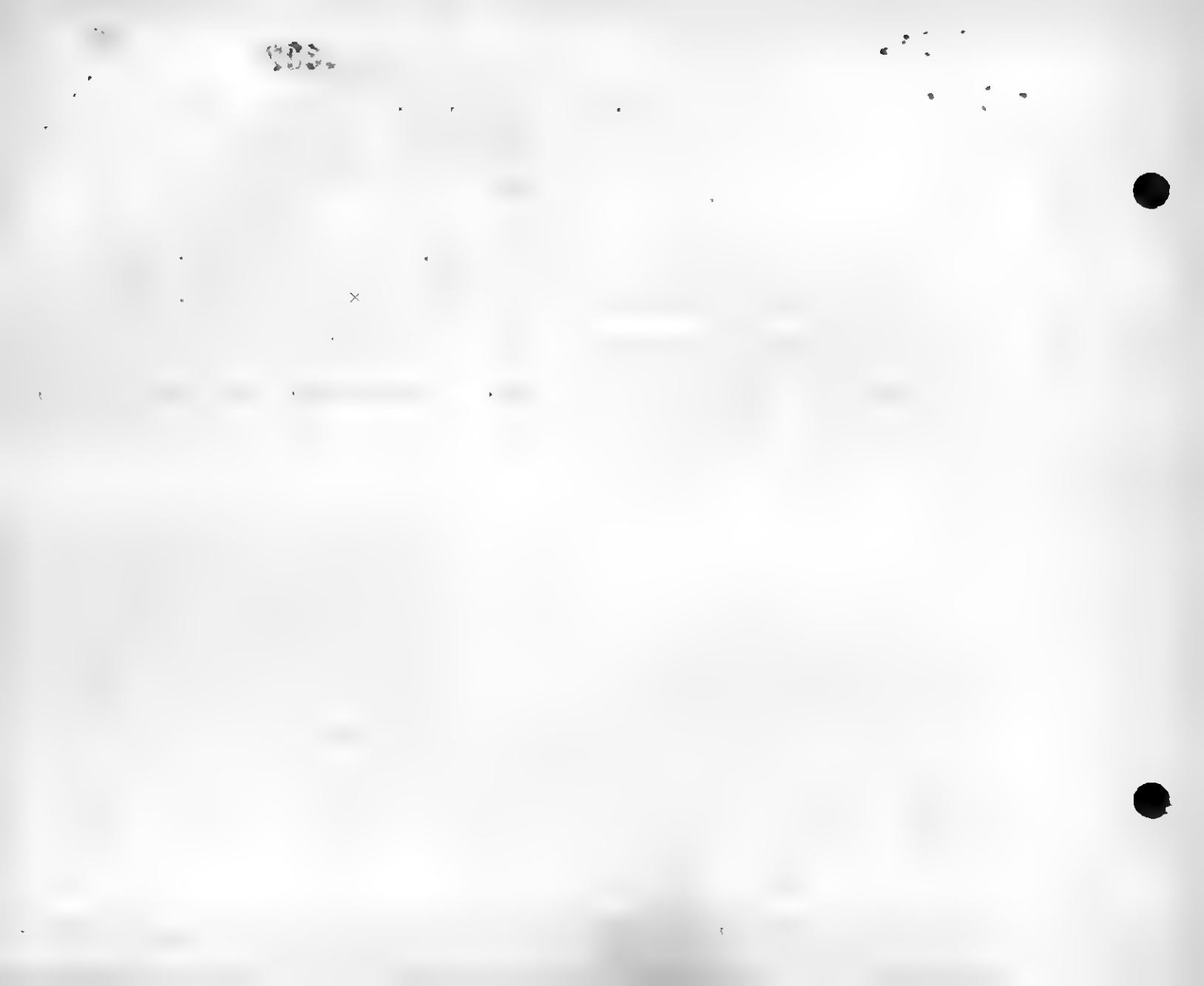
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
09336 09344														
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR					
CATHERINE ELIZABETH BAUGH						Month Day Year July 2 1968			3 A. M.					
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Female		W		Jan. 24, 1880			88 YRS.							
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
MARYLAND LARKO & Co			U. S.						Anne Arundel Co.			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Glen Burnie, Md.			Plaza Manor Nursing Home			Housewife								
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
Md.			BALTIMORE						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7014 Ft. Smallwood Rd. (26)		
14 FATHER'S NAME			15 MOTHER'S M A DEN NAME											
First Middle Last			First Middle Last											
George W. FRANK			Rachel Jane Cole FRANK											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address					
No			212-50-1231			Admission Sheet - Plaza Manor Nursing Home - Md.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION E Stroke														
DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS														
DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a DATE OF OPERATION														
19b CONDITION FOR WHICH OPERATION WAS PERFORMED														
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)														
21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19														
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>														
21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)														
21f LOCATION Street or R.F.D. No City or Town County State														
22a. I certify that (I) (th) (s) hospital) attended the deceased from APR. 12, 1967, to July 2, 1968, that (I) (we) saw the deceased alive on June 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE														
Richard H. Hunt														
22c. DATE SIGNED														
July 2, 1968														
22d. PHYSICIAN'S NAME (Type)														
Richard H. Hunt														
22e ADDRESS														
100 Cherry Lane, Glen Burnie, Md														
23a BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)														
Burial														
23b DATE														
July 5, 1968														
23c NAME OF CEMETERY OR CREMATORY														
Arlington Nat. Cemetery														
23d LOCATION (City or Town) (County) (State)														
Arlington, Virginia														
24 FUNERAL DIRECTOR														
George J. Gonc 4001 Ritchie Hwy. Balto. 21225														
25a REC'D BY REGISTRAR														
JUL - 8 1968														
25b REGISTRAR'S SIGNATURE														
Charles Judge														

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) Timothy J. Behegan, Sr.						2a. DATE OF DEATH 7 Month 16 Day 68 Year			2b. HOUR 5:27 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8-26-66 1885		6. AGE (In years last birthday) 82 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Vard Master (ret.)		12b. KIND OF BUSINESS OR INDUSTRY B&ORR					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Crownway Rd. (Southgate)			
14. FATHER'S NAME First Middle Last (Unknown) Behegan				15. MOTHER'S MAIDEN NAME First Middle Last (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unknown				16b. SOCIAL SECURITY NO 218-10-3808-A		17. INFORMANT Mr. Newton Behegan (son) Glen Burnie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>421</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 19 <u>68</u> , to <u>7-16</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>7-11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Alejandro Montoya</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>7-16-68</u>					
22d. PHYSICIAN'S NAME (Type) Dr. Alejandro Montoya				22e. ADDRESS 707 Old Annapolis Rd. N.E. Glen Burnie, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland					
24. FUNERAL DIRECTOR <u>Singleton</u>		SINGLETON FUNERAL HOME		25a. REC'D BY REGISTRAR DATE <u>JUL 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09346	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) WILLIAM H. BENSON			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 14 68			2b. HOUR 17 M					
3. SEX M	4. RACE W	5. DATE OF BIRTH 11-11-1906	6. AGE (in years and birthday) 61 YRS	IF UNDER 1 YEAR MONTHS DAYS 		F UNDER 24 HRS HOURS MIN. 		2c. DATE PRONOUNCED DEAD Month 7 Day 14 Year 68			2d. HOUR A - M
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL					
10. CITY OR TOWN OF DEATH EDGEWATER			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) RT #2 Box 74B			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PLUMBER & SCAFFOLDER			12b. KIND OF BUSINESS OR INDUSTRY TRANSIT		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD.			13b. COUNTY H.A.			13c. CITY OR TOWN EDGEWATER			13d. STREET AND NUMBER RT 2 Box 74B.		
14. FATHER'S NAME First RICHARD Middle H. Last BENSON			15. MOTHER'S MAIDEN NAME First ADEN Middle M. Last KING								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO WW 12			17. INFORMANT HENRY G. BENSON			ADDRESS # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac disease 4299 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Stroke DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Stroke	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION 7-17-68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 			21f. LOCATION Street or R.F.D. No. 			City or Town 		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E. Linhardt			M.D. 			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 7-14-68		
EXAMINER'S NAME (Type) E. Linhardt						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county) ANCO.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 7-17-68			23c. NAME OF CEMETERY OR CREMATORY BLANDFORD			23d. LOCATION (City or Town) (County) (State) PETERSBURG Va.		
24. FUNERAL DIRECTOR John M. Taylor & Sons			ADDRESS Annapolis, Md.			25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>09339</div> <div>09347</div> <div>Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100</div> <div>09339</div> <div>09347</div>									
<div>1 DECEASED NAME (Type or Print)</div> <div>CARLYLE LEE BARRETT BERRETT</div> <div>2a DATE KNOWN OF DEATH MATED</div> <div>Month 7 Day 28 Year 1968</div> <div>2b HOUR</div> <div>M</div>									
<div>3 SEX</div> <div>Male</div> <div>4 RACE</div> <div>White</div> <div>5 DATE OF BIRTH</div> <div>9/22/17</div> <div>6 AGE (In years last birthday)</div> <div>50 YRS</div> <div>7a BIRTHPLACE (State or foreign country)</div> <div>MD.</div> <div>7b CITIZEN OF WHAT COUNTRY?</div> <div>U S A</div> <div>8 MARRIED</div> <div><input checked="" type="checkbox"/> NEVER MARRIED</div> <div>9 COUNTY OF DEATH</div> <div>ANNE ARUNDEL</div>									
<div>10 CITY OR TOWN OF DEATH</div> <div>Bay Ridge</div> <div>11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Bay Ridge beach</div> <div>12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)</div> <div>Plumbing & Heating contractor</div> <div>12b KIND OF BUSINESS OR INDUSTRY</div> <div>PM</div>									
<div>13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE</div> <div>MD.</div> <div>13b CITY OR TOWN</div> <div>Hyattsville</div> <div>13c INSIDE CITY LIMITS?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div> <div>13d STREET AND NUMBER</div> <div>1414 Nicholson Street</div>									
<div>14 FATHER'S NAME</div> <div>Stanley Barrett</div> <div>15 MOTHER'S MAIDEN NAME</div> <div>Myrtle Henrietta Blackburn</div> <div>16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>W H</div> <div>16b SOCIAL SECURITY NO.</div> <div>17 INFORMANT</div> <div>Charlotte Barrett</div> <div>ADDRESS</div> <div>Hyattsville, Md.</div>									
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</div> <div>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</div> <div>Drowning</div> <div>19a DATE OF OPERATION</div> <div>19b CONDITION FOR WHICH OPERATION WAS PERFORMED?</div> <div>20. AUTOPSY?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>									
<div>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)</div> <div>21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</div> <div>21b TIME OF INJURY Month, Day, Year</div> <div>21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)</div> <div>Found in water presumably accidentally drowned</div> <div>21d INJURY OCCURRED</div> <div>21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)</div> <div>water</div> <div>21f LOCATION Street or R.F.D. No</div> <div>100 yds off-shore</div> <div>City or Town</div> <div>Bay Ridge beach</div> <div>County</div> <div>Bay Ridge, Prince George,</div> <div>State</div> <div>22a I certify that I took charge of the remains described above, held on</div> <div>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</div> <div>Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> <div>22b DATE SIGNED</div> <div>August 1, 1968</div>									
<div>23a BURIAL CREMATION, REMOVAL (Specify)</div> <div>Burial</div> <div>23b DATE</div> <div>Aug 5, 1968</div> <div>23c NAME OF CEMETERY OR CREMATORY</div> <div>Ft Lincoln Cemetery</div> <div>23d LOCATION (City or Town)</div> <div>Colmar Manor Pro Geo Md.</div> <div>24 FUNERAL DIRECTOR</div> <div>F. Gasch's Sons</div> <div>ADDRESS</div> <div>Hyattsville, Md.</div> <div>25a REC'D BY REGISTRAR</div> <div>DATE</div> <div>Aug 5 1968</div> <div>25b REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>									

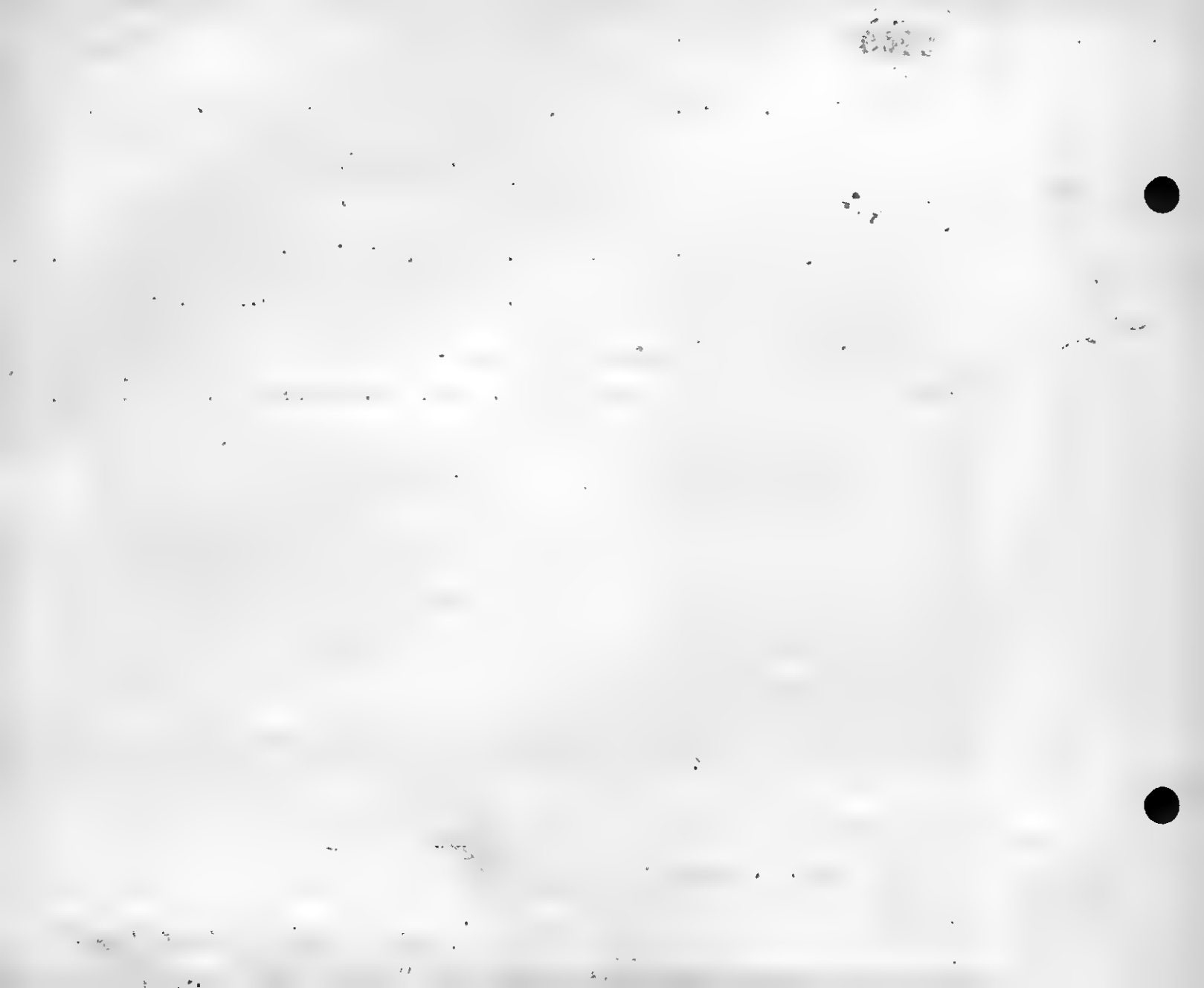


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

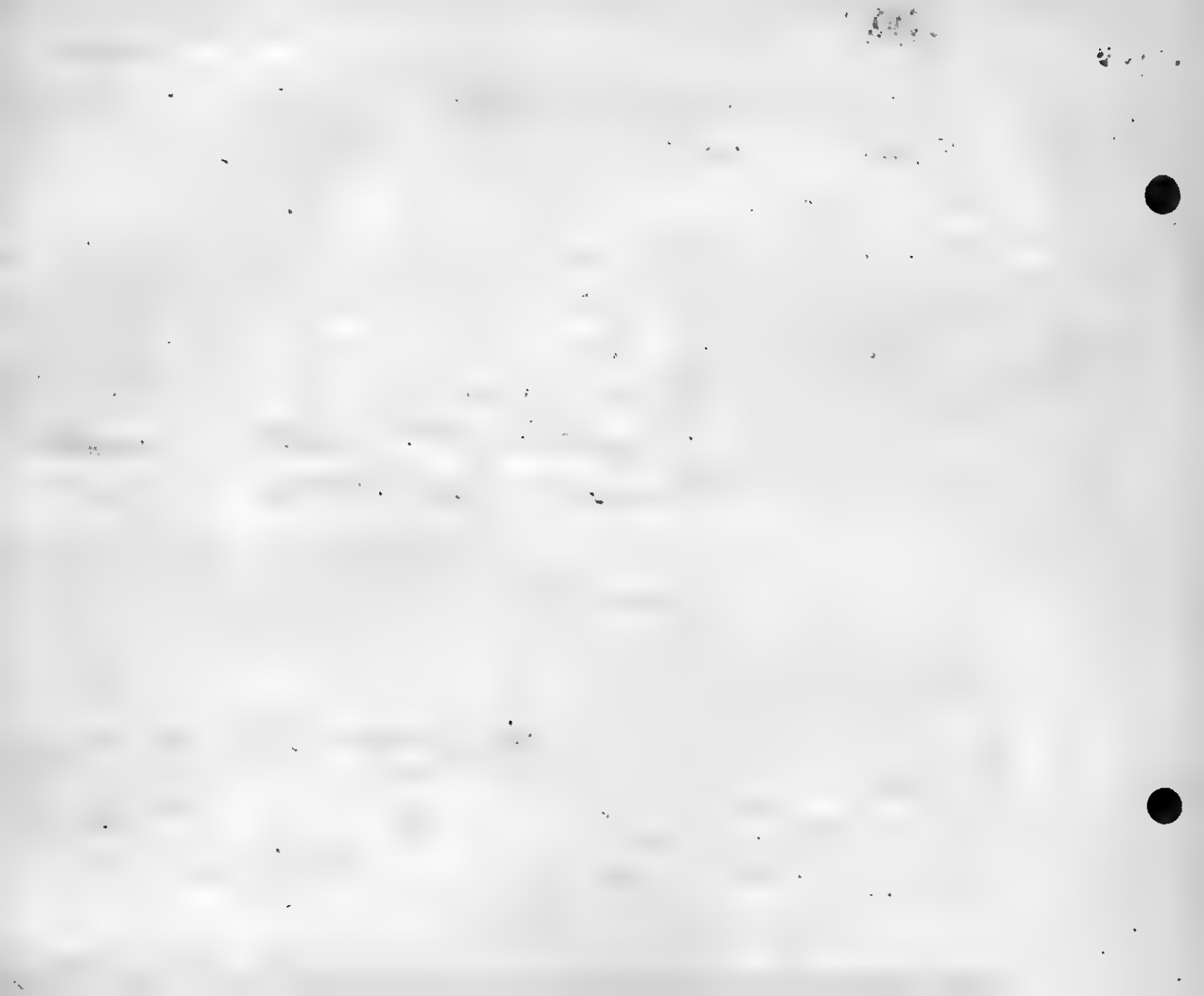
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR M		
Albert L. Bierman, Sr.						July 14 1968					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS			
Male		White		Dec. 4, 1905		62 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Anne Arundel County Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Linthicum Heights			Anne Arundel Co. Hosptl.			Engineer		B & O RR:			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Anne Arundel		Linth. Hgts		YES <input type="checkbox"/> NO <input type="checkbox"/>		603 E. Maple Rd.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Henry					Bierman	Carrie					Cole
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address					
No			----			Mrs. Albert L. Bierman, Sr. 603 E. Maple Rd. Linth. Hgts. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u>										1-2 weeks	
4129: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u>										5 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
222.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/12/68</u> , 19 <u>68</u> , to <u>7/14</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>7/12/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Chas. L. Ball</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>7/16/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Chas. L. Ball, Jr</u>						22e. ADDRESS <u>Linthicum Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		July 17, 1968		Western Cemetery		Baltimore		Anne Arundel		Md.	
24. FUNERAL DIRECTOR		ADDRESS		24b. BY REGISTERED		24c. DATE		24d. SIGNATURE			
Witzke Fun. Dir.		-4101 Edmondson Ave.		Baltimore, Md. 21229		JUL 18 1968		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

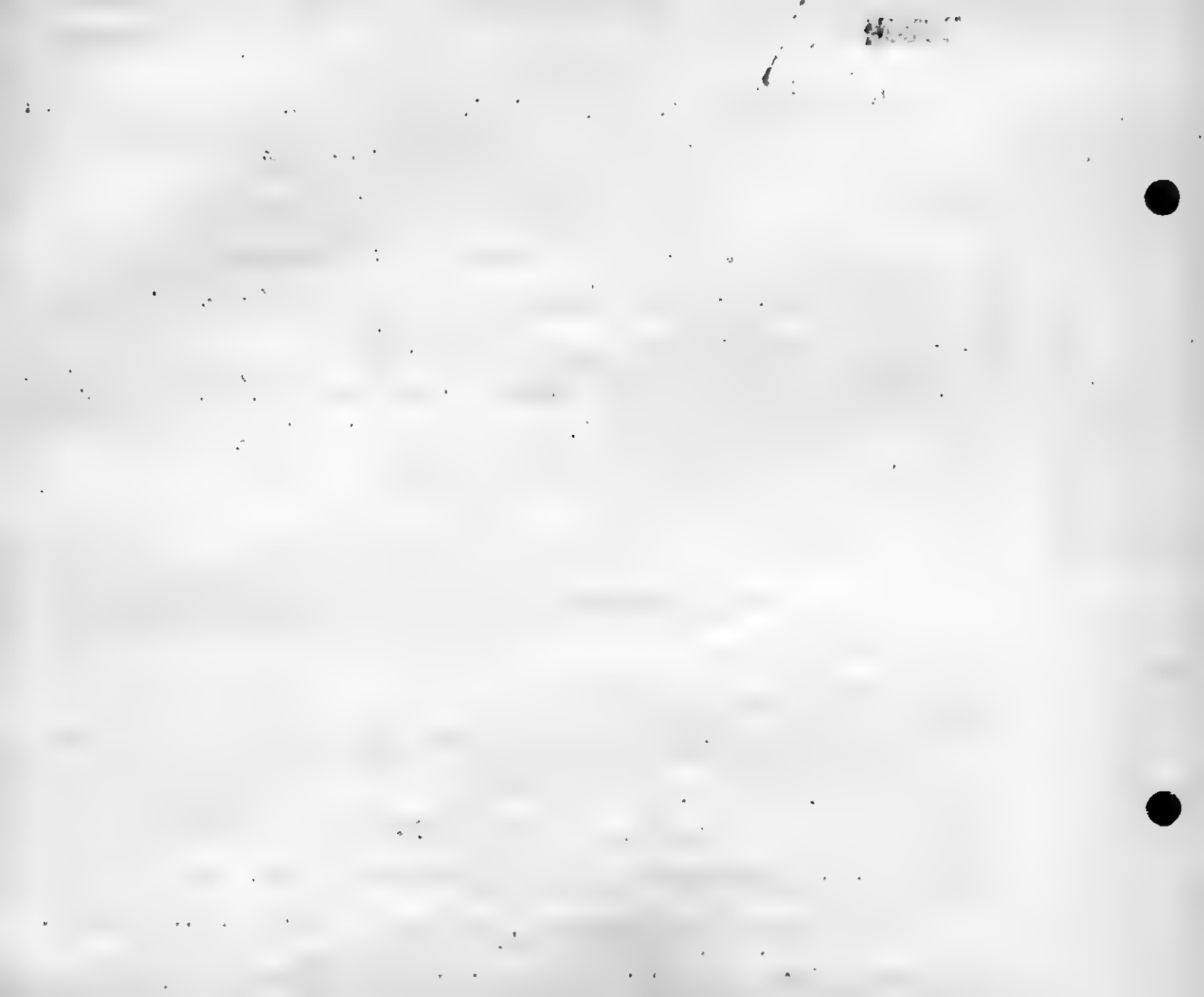
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Ruth Hartge Britt</i>						2a. DATE OF DEATH <i>July 3 1968</i>			2b. HOUR <i>4:30 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>APR. 22, 1892</i>		6. AGE (In years lost birthday) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>GALESVILLE, MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>A.A.</i>					
10. CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>A.A. GENERAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>RETIRED</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>RECREATION</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>GALESVILLE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First <i>Emile</i> Middle <i>ALEXANDER</i> Last <i>HARTGE</i>				15. MOTHER'S MAIDEN NAME First <i>SUSAN</i> Middle <i>EDGAR</i> Last <i>SILVER</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>579-48-6420A</i>		17. INFORMANT Address <i>Edgar F. Britt 1732 Overlook Dr Spring</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Rheumatic heart disease</i>										years	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
7.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1968</i> to <i>July 3 1968</i> , that (I) (we) lost saw the deceased alive on <i>July 3 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (aid) (did not) view the body after death.											
22b. SIGNATURE <i>Willard F. Smith</i>		DEGREE <i>PHYS</i>		ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/4/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Willard F. Smith</i>		22e. ADDRESS <i>Shady Side, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>July 6, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Luaker</i>		23d. LOCATION (City or Town) (County) (State) <i>Galesville, A.A., Md.</i>					
24. FUNERAL DIRECTOR <i>Hardisty + Son</i>		ADDRESS <i>Galesville, Md</i>		25a. REC'D BY REGISTRAR <i>JUL 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 J9350									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
MAUDE			C. BROWN			July 7 1968			1:00 A M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
F	Col		2-1-1894			74 YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
Charles Co. Md			U. S. A			Anne Arundel Co.			Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
ANNAPOLIS, MD			Anne Arundel Gen. Hospital			Self Employed			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			ANNE ARUNDEL			ANNAPOLIS		13e. STREET AND NUMBER	
								1970 FOREST Drive	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Samuel Marshall			ELIZA Thomas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
no			185-38-528			James Marshall 1518 F. Davis Drive SE Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Hypertensive Coroner DUE TO, OR AS A CONSEQUENCE OF (c) Vascular disease									5 Months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/19/68, to 7/7/68, that (I) (we) last saw the deceased alive on 7/7/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
R. L. Richardson								7/8/68	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
R. L. Richardson, MB.			Anne Arundel General Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			July 12, 1968			Lincoln Mem. Cemetery			Suitland, P. G., County, Md.
24. FUNERAL HOME			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hall Bros. Fun. Home			621 Fla. Ave.			JUL 11 1968		Charles Judge	
N. Washington, D. C.									

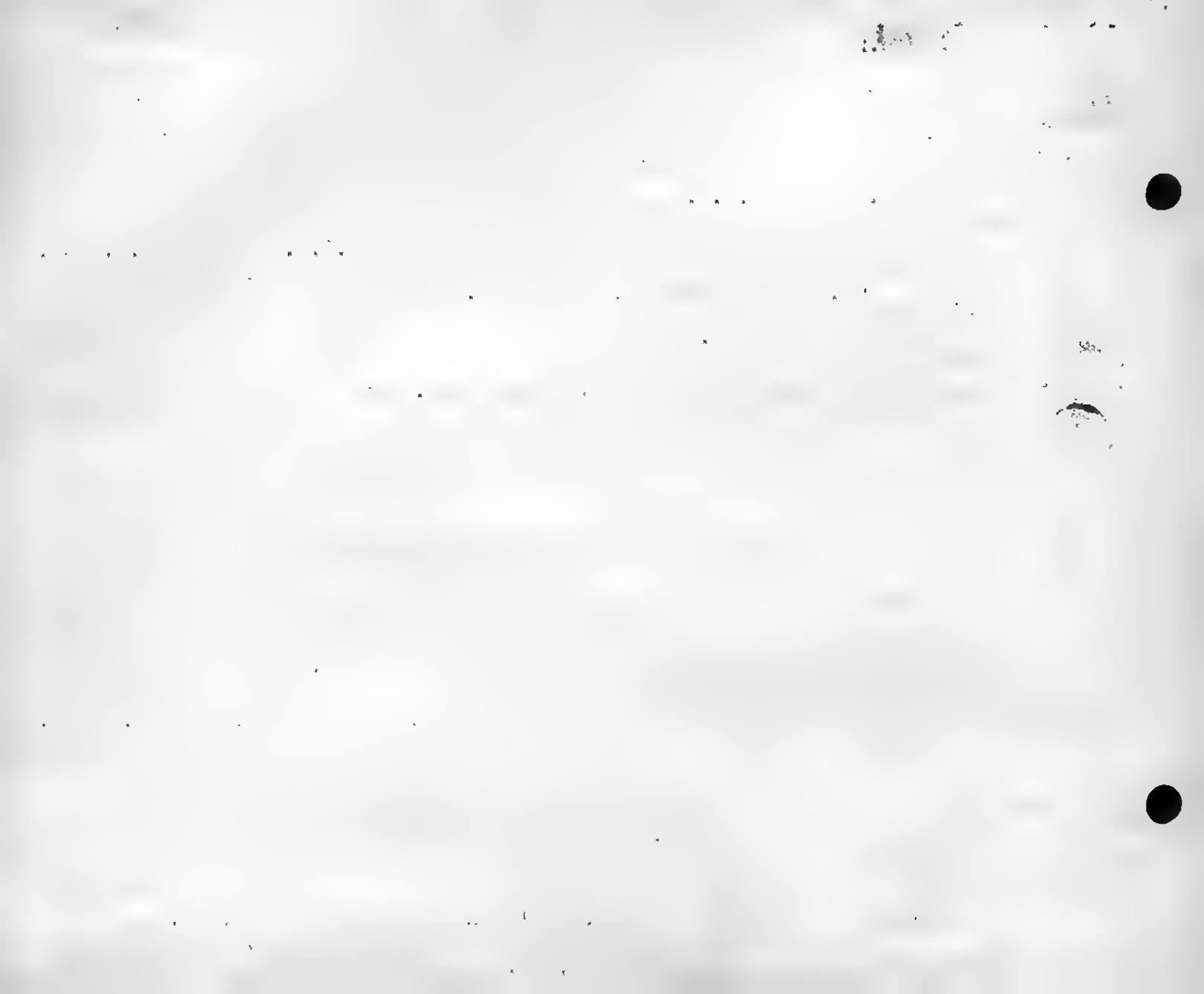


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
MARY		D.		BUGG				<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> July 19, 1968	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD		2d. HOUR
Female	White			17 YRS.			Month July Day 19, Year 1968		6:30 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ky.		U.S.A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		North Arundel Hospital				N.S.A.		U.S. Gov.	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY L.M.F.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Anne Arundel		Pasa.				2605-221 st Street	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
James		E.		Bugg				Dorthy Elmore	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		None		Unknown		Dorthy B. Bugg Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Extensive Body Burns</u> <u>8129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		4:40 AM July 19, 1968		Subject involved in head-on collision					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
		Street		Mountain Rd. Near Annapolis		A.A.		M.D.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 19, 1968	
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/23/68		Balto. Nat'l Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR		Singleton Funeral Home				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert P. Ware		Glen Burnie, Md.				JUL 22 1968		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

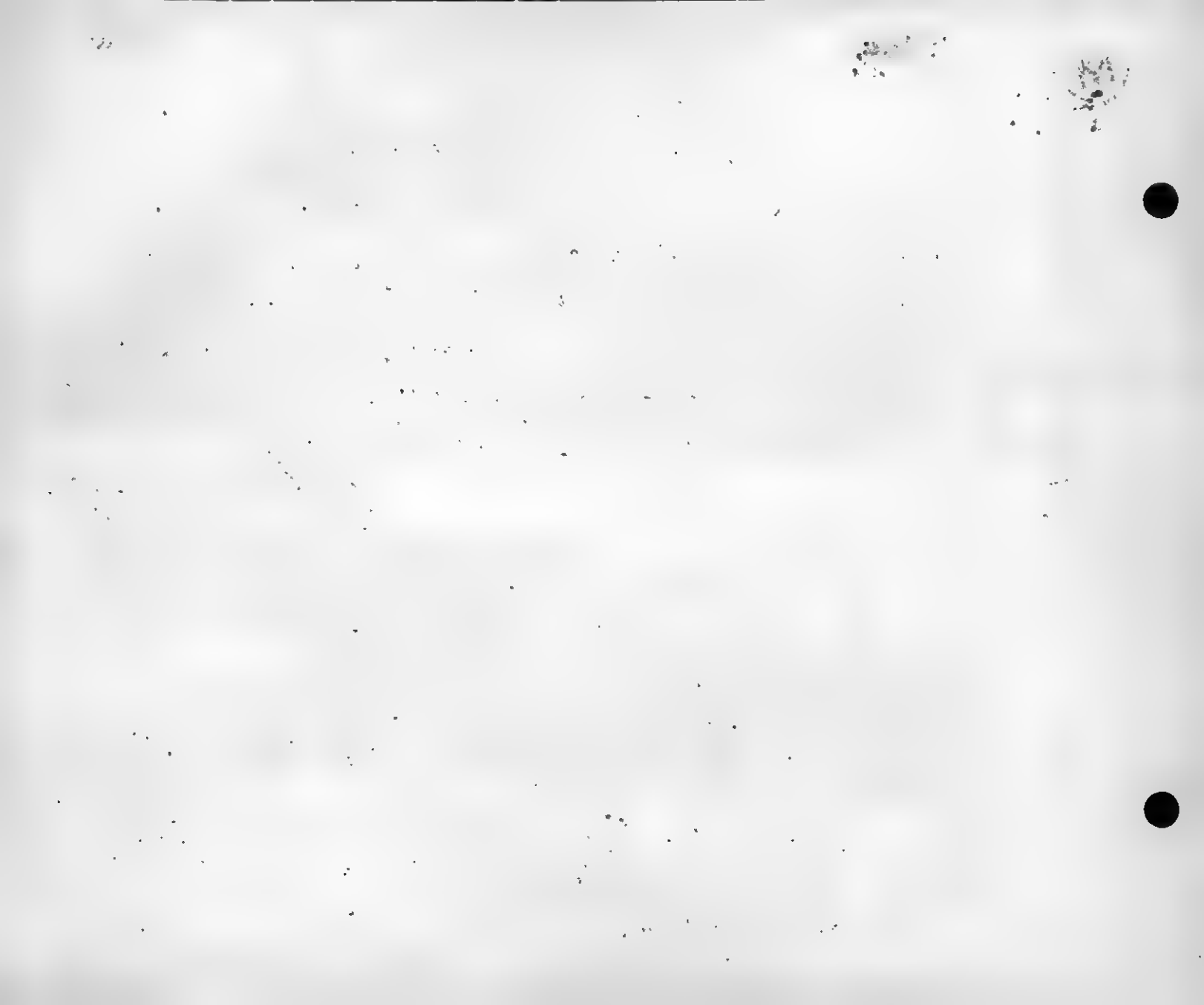
09344

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09352

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) STANLEY KARL BURK			2a DATE OF DEATH July Month 20 Year 1968		2b HOUR 4A M
3. SEX Male	4. RACE white	5. DATE OF BIRTH May 29 1898		6 AGE (In years last birthday) 70 YRS	7 UNDER 1 YEAR MONTHS — DAYS — HOURS — MIN —
7a. BIRTHPLACE (State or foreign country) N.Y. City	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Shadyside	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) No street address	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY DISTILLERY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md	13b. COUNTY A A	13c. CITY OR TOWN Shadyside	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER No street address	
14. FATHER'S NAME First JULIAN Middle BURK Last Ber nice	15. MOTHER'S MAIDEN NAME First CONRAD Middle — Last —				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) —	16b. SOCIAL SECURITY NO. 577-20-25180	17. INFORMANT Address Dorothea P Burk Shadyside Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Prostate					2 years
DUE TO, OR AS A CONSEQUENCE OF (b) —					
DUE TO, OR AS A CONSEQUENCE OF (c) —					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. — P.M. — Month — Day — Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) No injury	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. —		21f. LOCATION Street or R.F.D. No — City or Town — County — State —	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1967 to July 20, 1968 , that (I) (we) last saw the deceased alive on July 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles H. Wirth		22c. DATE SIGNED 7/22/68			
22d. PHYSICIAN'S NAME (Type) Charles H. Wirth		22e. ADDRESS Lothian, Md 20820			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 23, 1968	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) Suctland (County) PE (State) Md.	
24. FUNERAL DIRECTOR Bernard Hardesty		ADDRESS Lodgesville Md.		25a. REC'D BY REGISTRAR JUL 23 1968 25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)										2a DATE KNOWN OF DEATH		2b HOUR	
1 DAVID P. BUSKIRK										2a DATE KNOWN OF DEATH		2b HOUR	
3 SEX Male										4 RACE White		5 DATE OF BIRTH July 17, 1968	
6 AGE (In years last birthday) 22 YRS.										7 MONTHS 5		8 DAYS 5	
9a BIRTHPLACE (State or foreign country) Maryland										9b CITIZEN OF WHAT COUNTRY? U S A		9c MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Glen Burnie										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.										13b COUNTY A. A.		13c CITY OR TOWN Severn	
14 FATHER'S NAME First Middle Last Donald D. Buskirk										15 MOTHER'S MAIDEN NAME First Middle Last Sandra S. Blevins		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name and dates of service) None	
16b SOCIAL SECURITY NO None										17 INFORMANT Mr. Donald D. Buskirk (father)		18 ADDRESS Same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia complicating inflammation of umbilical artery										19a DATE OF OPERATION 7/23/68		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 7:23/1968	
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) Head laceration between eyebrows on left										21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home	
21f LOCATION Street or R.F.D. No. City or Town County State AA Md										22a EXAMINER'S SIGNATURE (Type) Warner H. Spitz, M.D.		22b DATE SIGNED July 23, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial										23b DATE July 25, 1968		23c NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	
23d LOCATION (City or Town) (County) (State) Glen Burnie, Md.										24 FUNERAL DIRECTOR Singleton Funeral Home		25a REC'D BY REGISTRAR DATE JUL 25 1968	
25b REGISTRAR'S SIGNATURE										25c REGISTRAR'S SIGNATURE		25d REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09346

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09354
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <u>Henry Howard Butler</u>			2a. DATE OF DEATH <u>Month Day Year</u> <u>7 20 1968</u>		2b. HOUR
3 SEX <u>Male</u>	4 RACE <u>Colored</u>	5 DATE OF BIRTH <u>6-2-1893</u>		6 AGE (In years <u>75</u> <u>YRS.</u>)	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) <u>Md.</u>	7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>A. A.</u>		
10. CITY OR TOWN OF DEATH <u>Annapolis</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>A. A. General Hospital</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Md.</u>	13b. COUNTY <u>A. A. Jones Station</u>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER	
14 FATHER'S NAME First Middle Last <u>Andrew Butler</u>	15 MOTHER'S MAIDEN NAME First Middle Last <u>Scott</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>No</u> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <u>216-079848</u>	17 INFORMANT <u>Beaman Butler Balto. Md.</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4120 Cardiovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year <u>19</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>68</u> , to <u>7/20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <u>430 AM</u>					
22b. SIGNATURE <u>R. L. Richardson</u>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>7/22/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON, M.D.</u>		22e. ADDRESS <u>110 Clay St., Annapolis, Md., 21401</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7-25-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		23d. LOCATION (City or Town) (County) (State) <u>Butlerstown Md.</u>	
24. FUNERAL DIRECTOR <u>William Beesett Annapolis Md.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First ESSEX			Middle NMN			Last CHAMP			2a DATE KNOWN OF DEATH ESTIMATED Month Day Year 7 10 19 68		2b HOUR M 9:05	
3 SEX Negro		4 RACE Male		5 DATE OF BIRTH 12-12-1902		6 AGE (in years last birthday) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS 7 10		IF UNDER 24 HRS HOURS MIN 9 05		2c DATE PRONOUNCED DEAD Month Day Year July 10 19 68		2d HOUR 9:05	
7a BIRTHPLACE (State or foreign country) Md				7b C.T. ZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel				Md.	
10. CITY OR TOWN OF DEATH Annapolis				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired) Laborer				12b. KIND OF BUSINESS OR INDUSTRY City			
13a USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b COUNTY A.A.				13c CITY OR TOWN Annapolis		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 2 - Box 294			
14. FATHER'S NAME First Middle Last Allen NMN Champ				15. MOTHER'S MAIDEN NAME First Middle Last Adelae NMN Jones											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO 214-05-2266				17. INFORMANT Alfred Champ				ADDRESS Rt 2 Box 294 Anne, Md			
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 8124															
19a. DATE OF OPERATION 7-14-1968				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Subject ran from woods in front of car				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 8:00PM 7 10 1968				21b. TIME OF INJURY Month, Day, Year 8:00PM 7 10 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subject ran from woods in front of car							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street				21f. LOCATION Street or R.F.D. No City or Town County State Rennell Highway A. A. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Charles S. Springate				EXAMINER'S NAME (Type) Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED July 11, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE 7-14-1968		23c. NAME OF CEMETERY OR CREMATORY Broadneck				23d. LOCATION (City or Town) (County) (State) Anne Arundel, Md					
24 FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Maryland				25a REC'D BY REGISTRAR JUL 16 1968				25b REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09348

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09356

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Atilda Luvinia CHASE			2a. DATE OF DEATH Month July Day 14 Year 1968			2b. HOUR 5:05 M			
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH Feb 26th 1914		6. AGE (In years last birthday) 54 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital		12. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 6414 Washington Ave	
14 FATHER'S NAME First George Middle Washington Last Williams			15. MOTHER'S MARDEN NAME First Minerva Middle Ann. Last Jackson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (in town) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 215-07-0182			17. INFORMANT Huerta Burrell Address 202 Cherry Lane Glen Burnie			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Renal Failure - Uremia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 193x (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypostatic Pneumonia; Decubitus Ulcers; Involutional Psychosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/26 , 19 68 , to 7/14 , 19 68 , that (I) (we) last saw the deceased alive on 7/14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Lionel M. Henry Mapp, M.D.		22c. DATE SIGNED 7/14/68		22d. PHYSICIAN'S NAME (Type) Lionel M. Henry Mapp, M.D.		22e. ADDRESS Crownsville State Hospital, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-18-68		23c. NAME OF CEMETERY OR CREMATORY St. Catharine's		23d. LOCATION (City or Town) (County) (State) Brooklyn Md			
24. FUNERAL DIRECTOR Wm. W. Wilson		ADDRESS 1000 Broadway Ave		25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE James J. Page			

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

09349

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09357

1. DECEASED NAME (Type or Print) VINCENT		First Middle Last		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 8/27/1915	
6. AGE (In years last birthday) 52 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Baltimore		10. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel General		11. COUNTY OF DEATH Anne Arundel	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1019 McKean Street			
4. FATHER'S NAME First Middle Last Thomas Childs		15. MOTHER'S MAIDEN NAME First Middle Last Frances Male			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 212-164337		17. INFORMANT Edna Childs ADDRESS 1019 McKean Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 1100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1100					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year July 20, 1968 HOUR A.M. 8:00		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Probably fell in water	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Water		21f. LOCATION Street or R.F.D. No. Severn River City or Town Anne Arundel County M.D. State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Ronald N. Kornblum		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED July 21, 1968	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ADDRESS (Street, city, town, or county)					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE July 24, 1968		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
24. FUNERAL DIRECTOR Joseph L. Luss		23d. LOCATION (City or Town) Baltimore (County) Md. (State) Md.		25a. REC'D BY REG. STRAP Jul 23 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in a casket, within 72 hours after death.

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #5, Film # 02 7/15 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Estella			(NMI)			CLARK			Month Day Year		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE		
F			H			Dec 12, 1909			57 YRS		
7a BIRTHPLACE (State or foreign country)			7b C T ZEN OF WHAT COUNTRY?			8 MARRIED			9. COUNTY OF DEATH		
Georgia			USA.			WIDOWED			H.A. CO.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Annapolis			DCHA - Anne Arundel - Gen								
13a USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
New Jersey			Cumberland			Bridgeton			YES NO		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO		
William			McCrinmon			Emma			257-48-7898		
17 INFORMANT			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
ANNIE MAE JOHNSON			Multiple Infarction			8/19/68					
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			20b TIME OF INJURY Month, Day, Year			20c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			20d AUTOPSY?		
PRIMARY			7-3 1968			auto accident Route 50			YES NO		
21a INJURY OCCURRED			21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21c LOCATION Street or R.F.D. No			21d CITY OR TOWN		
WHILE AT WORK			Highway			Route 50			County State		
22a I certify that I took charge of the remains described above, held and death resulted from			22b DATE SIGNED			22c NAME OF CEMETERY OR CREMATORY			22d LOCATION (City or Town) (County) (State)		
Natural causes			7/3/68			Rockhill			Jacksonville, Telfair Georgia		
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
BURIAL			July 8, 1968			Rockhill			Jacksonville, Telfair Georgia		
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			25c ADDRESS		
Charles F. Bell Jr.			JUL - 8 1968			Charles Judge			Hopping Funeral Home ANNAPOLIS, Md.		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH MATED		2b HOUR
Martha M Colbert								7-28 1968		A M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR
Female	Col.	9/21/1917	50 YRS.	MONTHS DAYS		HOURS MIN.		Month 7 Day 28 Year 68		A M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH		MD
Md.		U. S. A.		WIDOWED		DIVORCED		Anne Arundel		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Annapolis		23 C. C. Terrace		Housewife						
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.		A. A.		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		23 C. C. Terrace		
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last
Wesley		Isaac		Sarah		Tindell				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS				
No				Mary Bias 84 Clay St. Annap. Md.						
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Tuberculosis
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION										20 AUTOPSY?
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a I certify that I took charge of the remains described above, held on death resulted from.										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b DATE SIGNED						
E. Linhardt		E. Linhardt		1/28/68						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		8-1-68		Chews Memorial		Owensville, Md.				
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
William Reese, Jr.		Annap. Md.		Date 30 1968		James H. Jones				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then these remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, or removal, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09361

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
SOPHIA		V		CONTARINI	Month JULY Day 25 Year 1968		8:20 PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years)		7. UNDER YEAR		
Female	White		2-17-1870		lost 1899 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Italy		U.S.A.				A.A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Glen Burnie Md		North Arundel Hospital		Teacher					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md		Balto		Balto				2009 E Belvedere Ave Balt	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Carlo				Bosi	Victoria				Rossi
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
				Arthur V Contarini		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHTD</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Semibity</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/14/68</u> , 19 <u>68</u> , to <u>7/25/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/25/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Last, first, middle)					
<u>J. B. Raming</u>		<u>7/25/68</u>		<u>J. BRAMING MD</u>					
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS					
				<u>3927 Annapolis Rd Baltimore</u>					
				<u>325 Hospital Drive Glen Burnie</u>					
23a. BURIAL CREMATION, REINTERMENT		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REGISTRAR'S SIGNATURE	
<u>Burial</u>		<u>7/29/68</u>		<u>Lorraine Mausoleum</u>		<u>Baltimore, Maryland</u>		<u>John J. Judge</u>	
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE	
<u>Leonard J Ruck Inc.</u>		<u>Baltimore, Maryland</u>		<u>JUL 29 1968</u>		<u>John J. Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last			2a. DATE OF DEATH			2b. HOUR			
DAISIE COVINGTON			Month 7 Day 28 Year 1968			3:30 A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR MONTHS DAYS	
Female		White		Sept 12/1879		88 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Va.		U. S. A.				Anne Arundel			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Millersville			Kendall Manor Home AT HOME					HOMEMAKER	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER	
MD.			UNKNOWN					141 Dockser Drive	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
UNKNOWN			UNKNOWN			Henrietta Goode (niece)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
NO			NONE			MRS. AGNES GWINN 4406 KENDALL WOOD VILLAGE HOLIDAY FLA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Left ventricular failure								hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis								years	
DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis								day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
456									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/30, 1967 to 7/18, 1968, that (I) (we) last saw the deceased alive on 7/18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
MAX C. FRANK								7/29/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22f. SIGNATURE			
MAX C. FRANK				425 SE Ritchie Hwy - Glen Burnie MD 21061		Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
CREMATION		8/3/68		FT. LINCOLN		COLMAR MANOR PR. GEO. MD.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. W. CHAMBERS GO. 5201 CLEVELAND RIVERDALE, MD.				DATE AUG 6 1968		Charles Judge			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

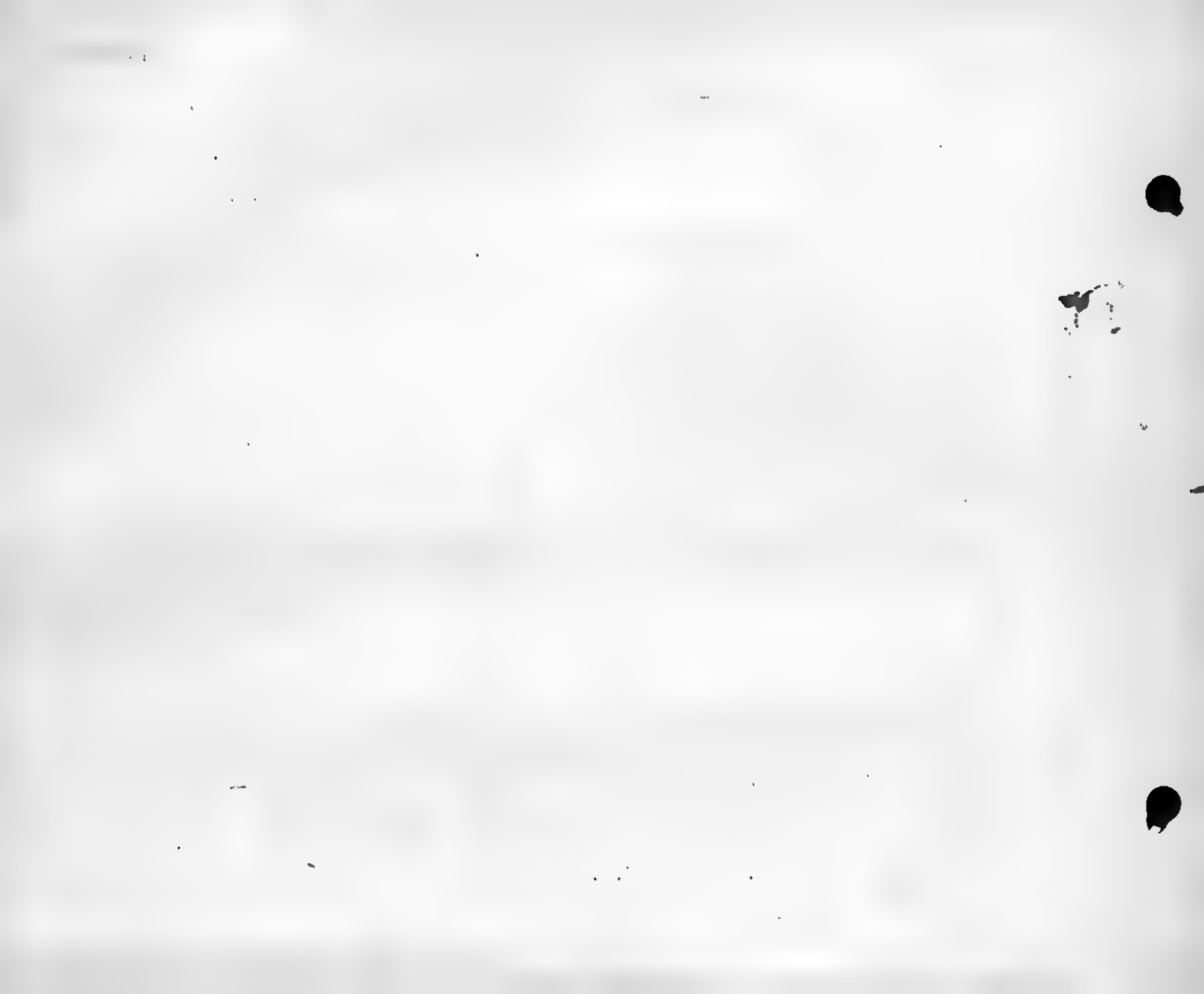
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 1-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI DEATH MATED <input type="checkbox"/> Month Day Year				2b. HOUR			
DORETHA FAYLAIN				DALE				7-8 1968				M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	F. UNDER 1 YEAR MONTHS DAYS		F. UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR		
Female	White			23 YRS					Sept. 7 1968				M		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel				Md.		
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Woods off Gambrills Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
2								?							
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Undetermined due to advanced decomposition</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>1760</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>last</u> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. ? 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>															
ACTUAL SIGNATURE <u>Edward F. Wilson</u>				M.D.				22b. DATE SIGNED Sept. 10, 1968							
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				ADDRESS (Street, city, town, or county)											
23a. BURIAL (CREMATION) REMOVAL (Specify)				23b. DATE 10.13.68				23c. NAME OF CEMETERY OR CREMATORY V. of Md. Med. School				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR DATE OCT 22 1968				25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) CHARLES N. DAVIS		First Charles		Middle N		Last Davis		2a DATE OF DEATH July Month 23 Day 68 Year		2b HOUR 7:35 P M	
3. SEX Male		4. RACE White		5 DATE OF BIRTH June 2, 1924		6 AGE (in years last birthday) 44 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 UNDER 24 HRS.	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel					
10. CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5 Sampson Place		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Superintendent		12b KIND OF BUSINESS OR INDUSTRY Buildings					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d INSIDE CITY (Y-N) YES		13e STREET AND NUMBER 5 Sampson Place			
4. FATHER'S NAME First Darcy Middle E. Last Davis		15. MOTHER'S MAIDEN NAME First Maude Middle ? Last McAllister									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO. WW 11		17. INFORMANT LeCompte Funeral Service records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Acute Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (b) Known ASCVD, Hypercholesterolemia DUE TO, OR AS A CONSEQUENCE OF (c) Ma, hypertriglyceridemia Condtions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 1 hour years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Had a large myocardial infarction 1 year ago											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 68 , to 7/23 , 19 68 , that (I) (we) last saw the deceased alive on 7/23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE 1081 Verkoen		DEGREE ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/23/68					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE July 25, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland					
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JUL 29 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

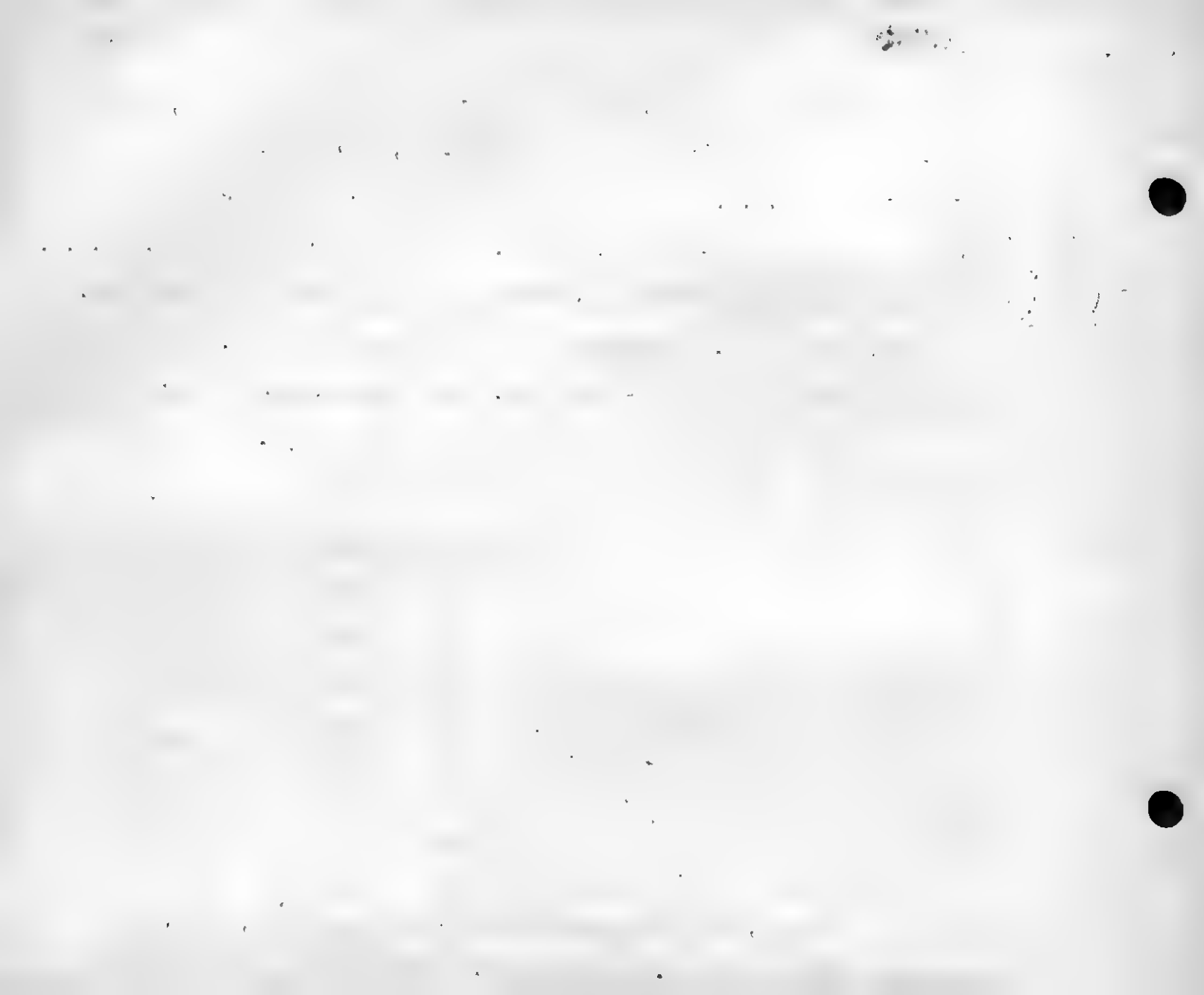
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Pete			Middle Dillard			Last Dillard			2a. DATE OF DEATH Month 7 Day 30 Year 68			2b. HOUR 9:15a M		
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH unknown 1907			6. AGE (In years last birthday) 61			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Unknown			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md								
10. CITY OR TOWN OF DEATH Crownsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) unknown			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 653 W. Conway Street					
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unknown			16b. SOCIAL SECURITY NO 220-03-0977			17. INFORMANT Hospital Records, Crownsville, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Renal insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension and dehydration												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 12/9, 1960, to 7/30, 1968, that (I) (we) lost saw the deceased alive on 7/30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b. SIGNATURE Charles R. Venter, M.D.			22c. DATE SIGNED 7/31/68			22d. PHYSICIAN'S NAME (Type) Charles R. Venter, M.D.			22e. ADDRESS Crownsville State Hospital, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 8-15-68			23c. NAME OF CEMETERY OR CREMATORY C. of Md. Med. School			23d. LOCATION (City or Town) (County) (State) Baltimore Md.								
24. FUNERAL DIRECTOR			25a. RECD BY REGISTRAR DATE AUG 16 1968			25b. REGISTRAR'S SIGNATURE J. Charles Jones											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or print)						First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
LEONARD						JOSHUA		DISNEY				July 4, 1968			
3 SEX			4. RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			7 IF UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN.	
Male			White			Jan. 29, 1885			83						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Maryland			U.S.A.						Anne Arundel Md						
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Odenton				1411 Annapolis Rd.				Signal Maintainer (ret.)				P.R.R.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland				Anne Arundel				Odenton				#1411 Annapolis Rd.			
14. FATHER'S NAME						First		Middle		Last		15. MOTHER'S MAIDEN NAME			
Nicholas						M.				Disney		Rachael L. (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.				17 INFORMANT				Address			
No				None				717-07-6244				Mrs. Mary Ahmuty (daughter) Same as #2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 yrs</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>443X</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1968</u> , to <u>July 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Frank E. Shupley M.D.</u>				22c. DATE SIGNED <u>7/5/68</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (Type) <u>Shupley M.D.</u>				22e. ADDRESS <u>Source M.D.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				July 8, 1968		Nicholas-Bethel Cemetery Odenton, Maryland									
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Singleton Funeral Home				Glen Burnie, Md.				JUL - 8 1968		<u>Charles Judge</u>					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

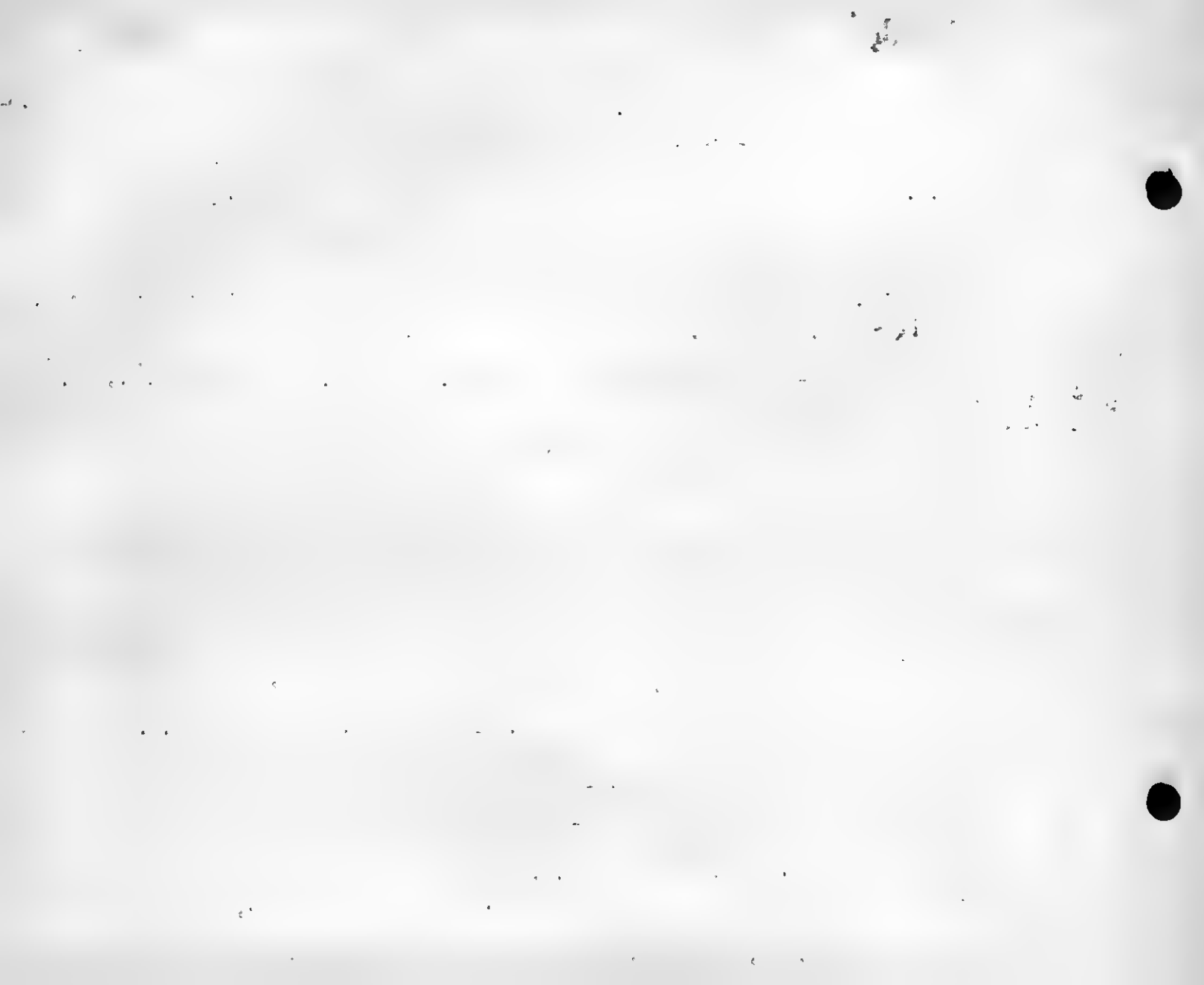
M

09958

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09866

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED Month Day Year				2b HOUR	
LESLIE V. DIXON						7 13 1968				9:10	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
Male	White	6-17-34	34 YRS					July 13 19 68		9:10	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED WIDOWED		NEVER MARRIED DIVORCED		9 COUNTY OF DEATH			
D.C.		USA						Anne Arundel Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Baltimore Annapolis		Anne Arundel General				Salesman		Auto			
13a USUAL RESIDENCE (Where deceased lived, if not at an admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			PG		Hyattsville				5233 Kenilworth Ave.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Harry T. Dixon Sr.			Ruth Young								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS			
Yes			1938-55		Harry T. Dixon Jr.			Upper Marlboro, 10804 Tyrone Dr., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Craniocerebral injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>2234</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOURS MIN 7:50 P.M. 7 13 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Driver, ran off road, overturned</u>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Street</u>		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
				Ty. 258 N. of Rt. 2		A.A.				Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u>			EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
					ADDRESS (Street, city, town, or county)		22b DATE SIGNED July 14, 1968				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		7-17-68		Cedar Hill Cemetery		Suitland, Maryland					
24 FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland, Rd. SE, Suitland, Maryland						25a REC'D BY REGISTRAR DATE JUL 19 1968		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First Middle Last						Month Day Year			M. A. N.		
ADOLPH EISENRAUCH						July 29, 1968			11 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Oct. 30, 1877		90 YRS.		MONTHS DAYS HOURS		M. A. N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Austria		U.S.A.				Anne Arundell Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
High Point						Cabinet Maker			Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Arundel			High Point			7728 Glenn Avenue		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Anton Eisenrauch			Anne Marie ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
NO			213 03 5527			Mr Frank W. Eisenrauch Pasadena Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1129										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF										2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										10 yrs.	
DUE TO, OR AS A CONSEQUENCE OF										15 yrs.	
(c) Arteriosclerosis general											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1/29, 1956, to 7/29, 1968, that (I) (we) last saw the deceased alive on 7/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
Joseph Tyler M.D.						7/31/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Joseph Tyler M.D.						45 Approach Rd. Glen Burnie, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		8/2/68		Sacred Heart Cemetery		Baltimore Maryland					
24. FUNERAL DIRECTOR ADDRESS						25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henry Sander & Sons Inc. Balto. Md.						AUG 2 1968		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

09360

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

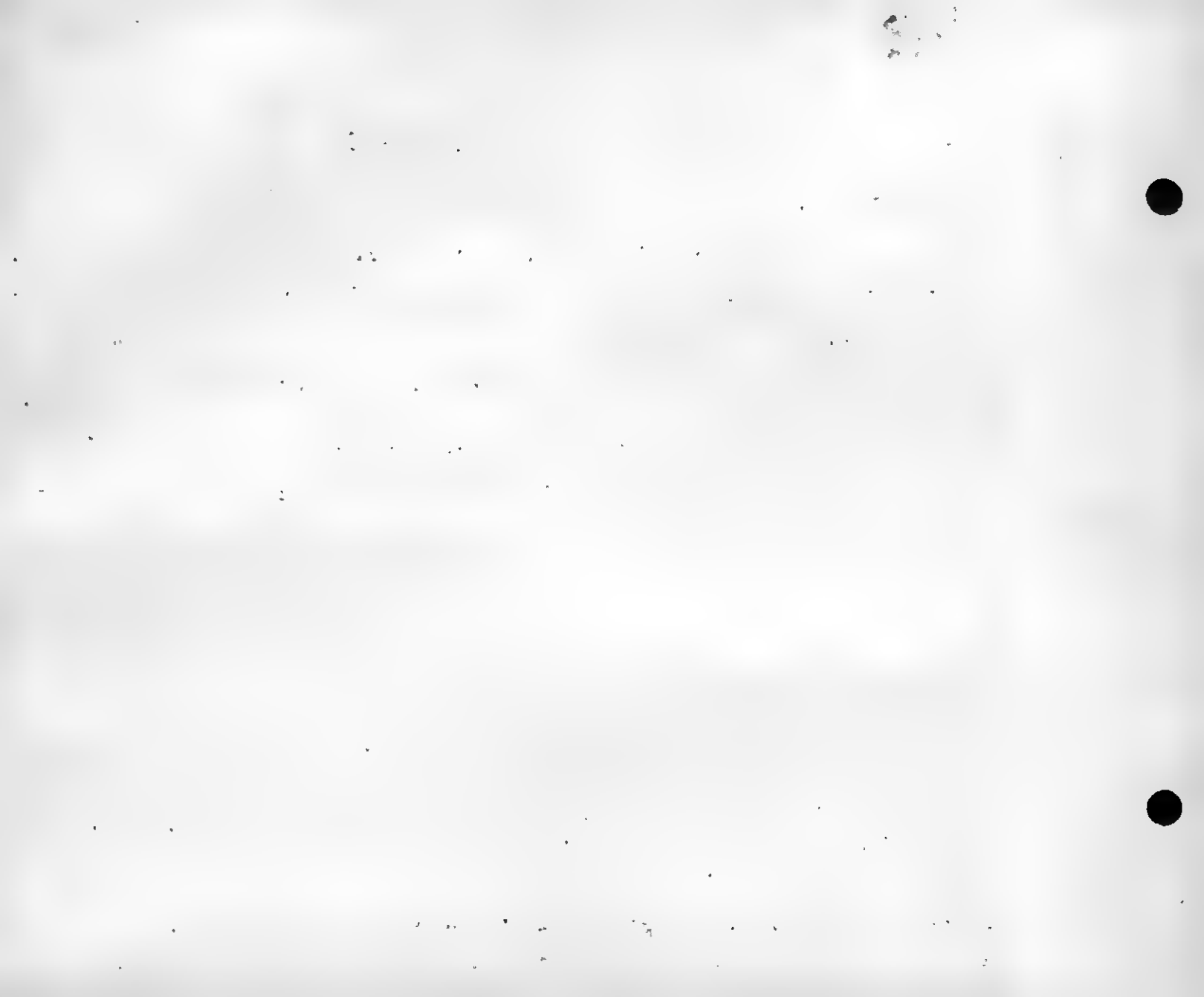
09368

1 DECEASED-NAME (Type or print) <i>Einar G. E. Engberg</i>			2a. DATE OF DEATH Month <i>7</i> Day <i>11</i> Year <i>1968</i>			2b. HOUR <i>9:50</i> AM					
3 SEX <i>M.</i>		4 RACE <i>W.</i>		5. DATE OF BIRTH <i>May 5, 1889</i>		6. AGE (In years last birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Sweden</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>A.A.</i>		Md			
10 CITY OR TOWN OF DEATH <i>Arnold</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired - USE EXP. Station</i>		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md</i>		13b. COUNTY <i>GA</i>		13c CITY OR TOWN <i>Arnold</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>Arnold rd.</i>			
14 FATHER'S NAME First <i>John</i> Middle <i>ENGBERG</i> Last <i>MARY</i>			15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>ENGBERG</i> Last <i>ENGBERG</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT <i>FAMILY</i>			Address <i>Same</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Brain Uremia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ca. Prostatic gen</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coxenomatosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19__, to <i>1968</i> , 19__, that (I) (we) last saw the deceased alive on <i>7-9-68</i> 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death.											
22b. SIGNATURE <i>Robert R. HAHN</i>		22c. DATE SIGNED <i>7-11-68</i>		22d. PHYSICIAN'S NAME (Type) <i>Robert R. HAHN</i>							
23a BURIAL, CREMATION, REMOVAL, (Specify)		23b DATE <i>July 15, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Holy Ransom Cem.</i>		23d LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
24. FUNERAL DIRECTOR <i>Severna Park Funeral Home</i> <i>Robert A. Sansano</i>		ADDRESS <i>Severna Park</i>		25a REC'D BY REGISTRAR <i>Jul 15 1968</i>		DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR			
JOHN FAIRLEY						July 11, 1968		M			
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male		White		Aug. 25, 1888,		79 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore Md.		USA				Anne Arundel Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Arnold			Shore Acres Rt. 3 Box 401			Fireman, Baltimore City Ret.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Shore Acres, Arnold			Anne Arundel County					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 3 Box 401 Arnold Md.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Robert Fairley			? Biggerman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address					
no			217-26-3315			William C. Fairley. Rt. 3. Box 401 Arnold Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic adenocarcinoma (primary unknown)</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unknown</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> , 1966, to <u>7/11</u> , 1968, that (I) (we) lost saw the deceased alive on <u>6/39</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>Richard I. Hochman, M.D.</u>								7/11/68			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Richard I. Hochman, M.D.			16 Murray Ave., Annapolis, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		July 15, 1968		Parkwood Cemetery		Baltimore Md.					
24. FUNERAL DIRECTOR ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
HENRY SANDER & SONS, INC. Baltimore Md.			JUL 15 1968			<u>Charles Judge</u>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

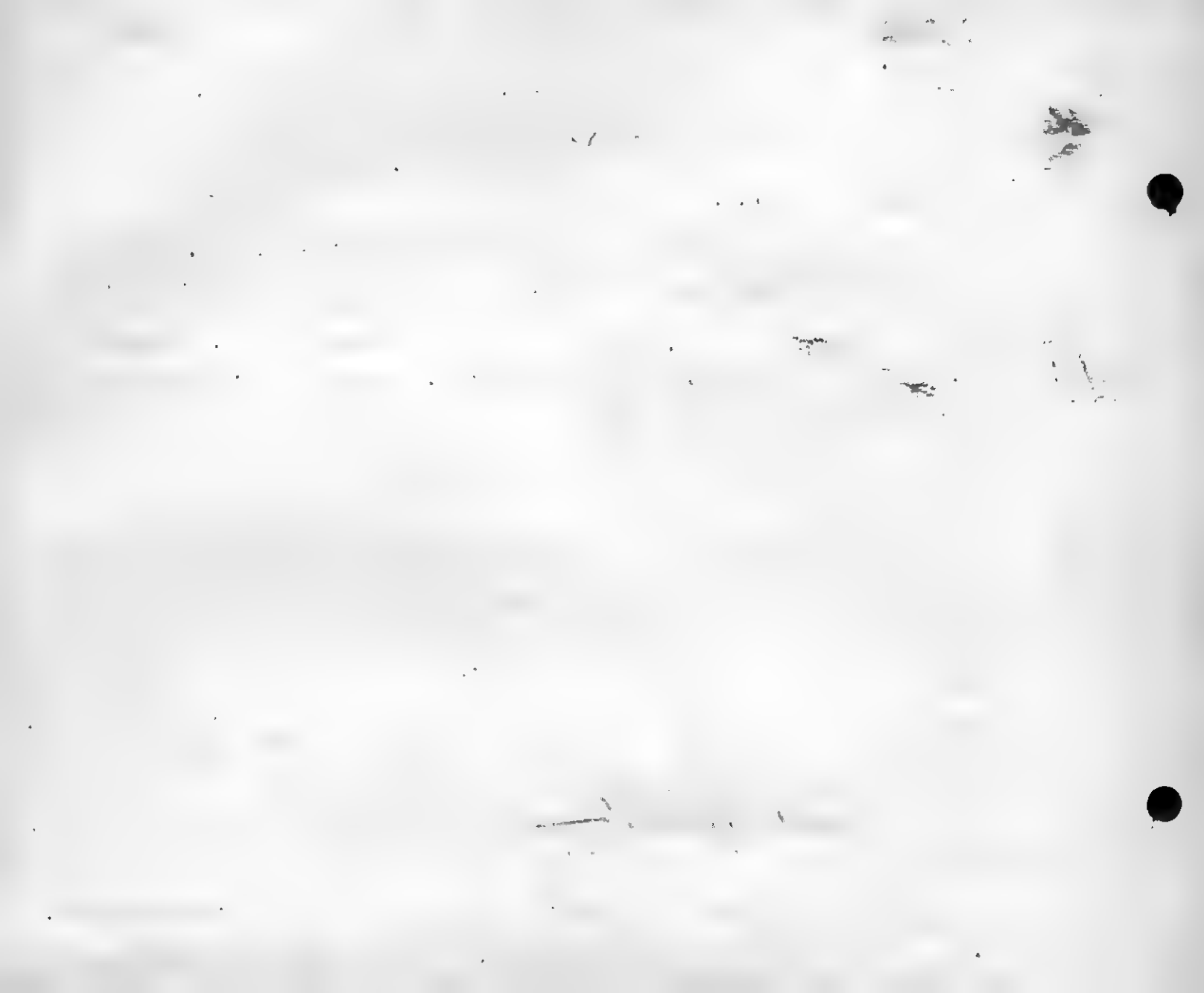
89362

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

89370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) MELVINA		First C		M date FISHER		Last		2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year MATED <input checked="" type="checkbox"/> July 19, 1968		2b HOUR :55 A	
3 SEX Male	4 RACE White	5 DATE OF BIRTH August 19, 1939		6 AGE (in years and by day) 28 YRS	F UNDER YEAR MONTHS : DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year July 19, 1968		2d HOUR :25 M
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Employee-Balte Co. School Board		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 122 Sanford Ave 21228			
14. FATHER'S NAME George W. Fisher		First Middle Last		15. MOTHER'S MAIDEN NAME Georgia C. Barnes		First Middle Last					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		(If Yes give year or dates of service)		16b SOCIAL SECURITY NO. 218 36 4547		17. INFORMANT George W. Fisher ADDRESS 122 Sanford Ave-21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 7100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 7100 DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7298											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 7-19 19 68 P. M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subject dove off boat							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Water		21f. LOCATION Street or R.F.D. No Anne Arundel M.D.		City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		EXAMINER'S NAME (Type)		301 Frederick Rd.		22b DATE SIGNED July 19, 1968		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-22-1968		23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION (City or Town) (County) (State) Howard County--Maryland.					
24. FUNERAL DIRECTOR Edw Mac Nab Jr		25a. REC'D BY REGISTRAR JUL 22 1968		25b. REGISTRAR'S SIGNATURE J Charles Jones							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
304 REV 1-58

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
William B Fogler								July Month 24 1968		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Dec 11, 1911		56 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md		USA				AA CO					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		No Arundel Gen Hosp		Baker							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md		AA Co		Pasadena				221 Glen Rd			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
Robert B Fogler		Sarah									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
				Family		Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 yr.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from JAN 1968, to 7/24 1968, that (I) (we) lost saw the deceased alive on 7/10 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
J. Brady Smith		7/20/68		J. BRADY SMITH		RIVIERA BEACH, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATED ON (City or Town) (County) (State)					
Burial		7/29/68		Glen Haven Cem		Glen Burnie AA Co Md					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Mc Callister F.H. 7378 Latopaw ave		21225		JUL 29 1968		Charles Jones					

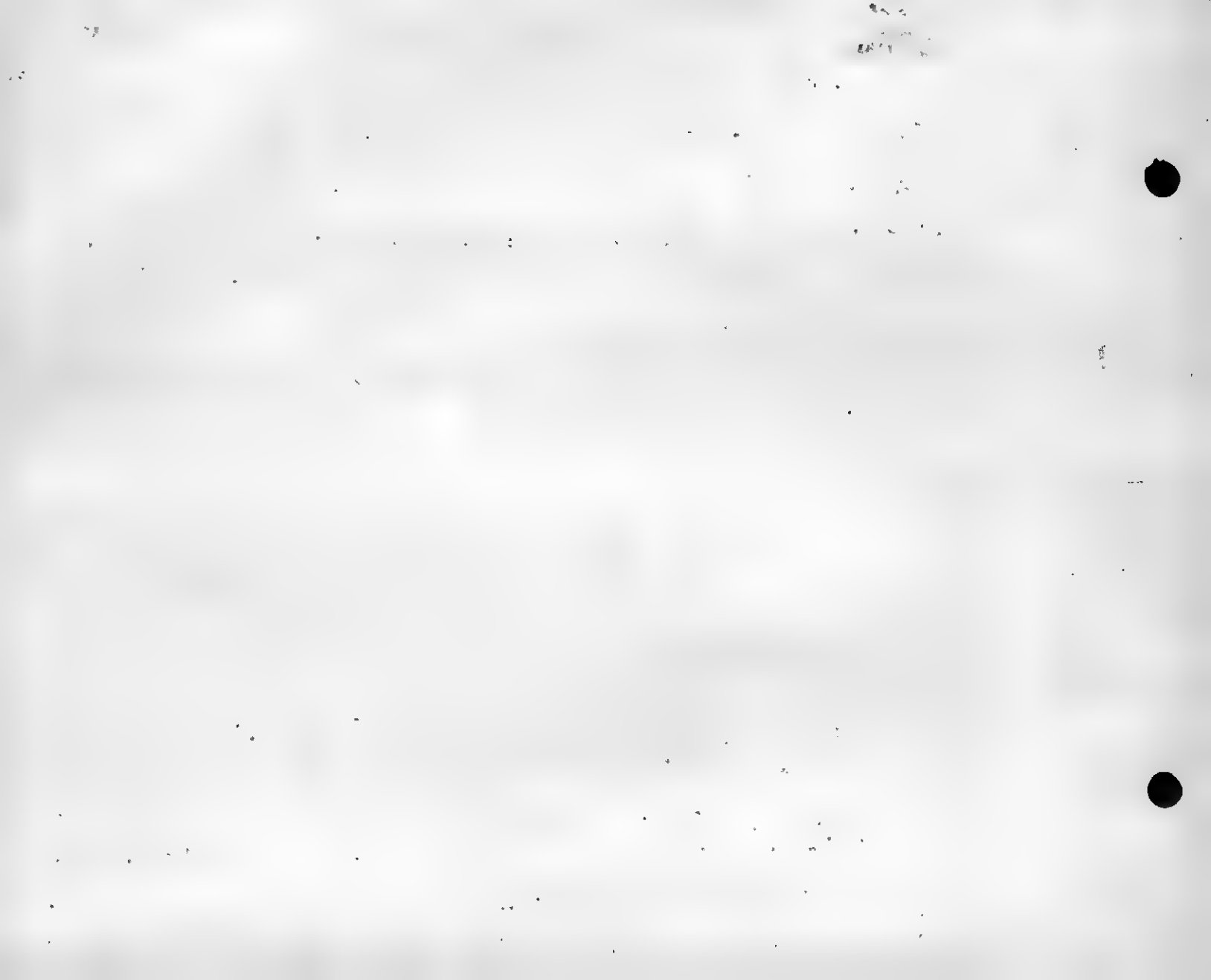
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First PETER	Middle JOHN	Last FONTAINE	2a. DATE OF DEATH JULY Month 15 Day 1968 Year		2b. HOUR 2:30 P.M.		
3 SEX Male		4 RACE White		5. DATE OF BIRTH 13 July 1968		6. AGE (In years lost birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS 2	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Fort Geo G. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kimbrough Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Newborn		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Md		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Ft Meade		13d. INSIDE CITY & IN 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1906 Patton Drive	
14. FATHER'S NAME First John Middle H. Last Fontaine		15. MOTHER'S MAIDEN NAME First Helga Middle Last Schneider							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give year or dates of service) N/A		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Helga Fontaine, 1906 Patton Drive, Ft Meade, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (c) Extreme Prematurity 777x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from 13 July, 1968, to 15 July, 1968, that (I) (we) last saw the deceased alive on 15 July, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph H. Wearn MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 15 July 1968			
22d. PHYSICIAN'S NAME (Type) JOSEPH H. WEARN, MAJ, MC		22e. ADDRESS Kimbrough Army Hosp, Ft Geo G. Meade, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE JULY 19, 1968		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		23d. LOCATION (City or Town) ARLINGTON		(County) (State) VA.	
24. FUNERAL DIRECTOR Charles Judge		ADDRESS 550 WASH BLVD Md.		25a. REC'D BY REGISTRAR DATE JUL 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



3
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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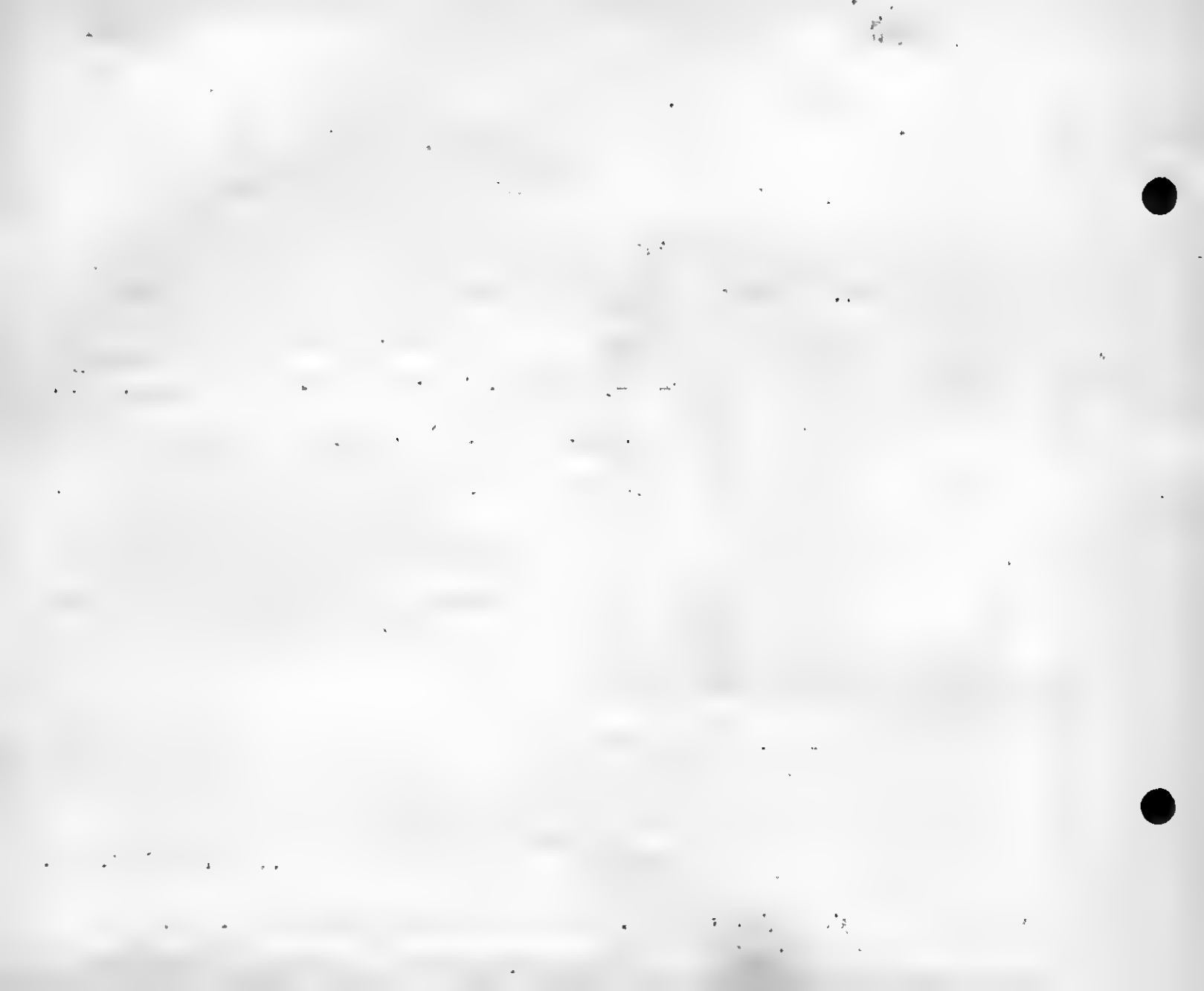
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First ANNA	Middle H.	Last FONTZ	2a. DATE OF DEATH Month JULY		Day 30,	Year 1968	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 8, 1893		6. AGE (In years last birthday) 75 YRS		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL		Md.		
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) #210PHELPS AVE.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWORK		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GLEN BURNIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER #2 Bertram Circle	
14. FATHER'S NAME First FRANKLAND			Middle HASLUP		Last MARY		15. MOTHER'S MAIDEN NAME First E.		Last ROGERS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 216 05 7750-D		17. INFORMANT Mrs. Lillian A. Haupt (daughter)		Address SAME AS # 11			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>189.0</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of right kidney</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>180x</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>10/18/</u> , 19 <u>62</u> , to <u>1/30/</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/28/</u> , 19 <u>68</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Edmond I. Moushabeck</u>					DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/30/68</u>	
22d. PHYSICIAN'S NAME (Type) EDMOND I. MOUSHABEK					22e. ADDRESS 510 MARLEY STATION ROAD GLEN BURNIE, Md. 21061					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE AUGUST 2, 1968		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PK.		23d. LOCATION (City or Town) GLEN BURNIE, MARYLAND		(County) (State)		
24. FUNERAL DIRECTOR		SINGLET NADP		GENERAL HOME		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 09366 CERTIFICATE OF DEATH 09374 </div>									
1 DECEASED NAME (Type or print) MARY B. FORD					2a. DATE OF DEATH Month July 1 Year 68		2b. HOUR M		
3 SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 7 1888		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH ANNEAPOLIS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bay Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 21 Madison Place	
14 FATHER'S NAME First John Middle Frank Last Frank			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Hahn Last Frank						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 220-36-5409		17 INFORMANT Mrs. Estelle Musterman		Address 8 Cheston Ave Anna., Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Int. Scler. C.V. Disease 1124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. several small strokes (b) year (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7271 Pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 1966 to present 19 68 , that (I) (we) last saw the deceased alive on June 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John L. Heleman		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 2, 68			
22d. PHYSICIAN'S NAME (Type) JOHN L. HEDEMAN MD		22e. ADDRESS 1407 Forest Dr., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 3, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis, Md.			
24 FUNERAL DIRECTOR Beall Funeral Home		ADDRESS 1212 West St. Anna Md		25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
1. DECEASED-NAME (Type or print) Teresa First M. Middle France Last						2a. DATE OF DEATH 7 Month 10 Day 68 Year			2b. HOUR 4:05 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4-21-20		6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Ann Arundel County Md.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ann Arundel Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Wholesale App.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY A.A.Co.		13c. CITY OR TOWN Perndale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 405 Oakleigh Ave.			
14. FATHER'S NAME First John Middle Spazak Last				15. MOTHER'S MAIDEN NAME First Eleanore Middle Michamalski Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 215 03 9247		17. INFORMANT Address Baltimore, Md. Miss Margaret France (sister-in-law)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) metastatic carcinoma of Brain 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 170X											
19a. DATE OF OPERATION July 1967		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cx of Breast				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6-25 , 19 68 , to 7-10 , 19 68 , that (I) (we) last saw the deceased alive on 7-10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ernest Tolentino				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED July 10, 1968			
22d. PHYSICIAN'S NAME (Type) Ernest Tolentino				22e. ADDRESS N.A.H. - Glen Burnie, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park, Glen Burnie, Md.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.					
24. FUNERAL DIRECTOR R. J. Singleton		24a. ADDRESS Singleton Funeral Home		24b. CITY Glen Burnie, Maryland		24c. REC'D BY REGISTRAR JUL 11 1968		24d. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 28868 CERTIFICATE OF DEATH 9376 </div>											
1. DECEASED-NAME (Type or print)			First TONY			Middle ALAN			Last GABRIEL		
2a. DATE OF DEATH			Month JULY			Day 8			Year 1968		
2b. HOUR			8:05 PM								
3. SEX			MALE			4. RACE			CAUCASIAN		
5. DATE OF BIRTH			8 JULY 1968			6. AGE (In years last birthday)			YRS.		
7a. BIRTHPLACE (State or foreign country)			MARYLAND			7b. CITIZEN OF WHAT COUNTRY?			U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			ANNE ARUNDEL			Md.		
10. CITY OR TOWN OF DEATH			FT. GEORGE G. MEADE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			U.S. KIMBROUGH ARMY HOSP.		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			newborn			12b. KIND OF BUSINESS OR INDUSTRY			newborn		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)			STATE MARYLAND			13b. COUNTY			ANNE ARUNDEL		
13c. CITY OR TOWN			HARMANS			13d. INSIDE CITY LIMITS?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER			OLD DORSEY ROAD, APT #6								
14. FATHER'S NAME			First DOUGLAS			Middle J.			Last GABRIEL		
15. MOTHER'S MAIDEN NAME			First LINDA			Middle RUTH			Last COLLINS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			NO			16b. SOCIAL SECURITY NO.			N/A		
17. INFORMANT			Address DOUGLAS GABRIEL, OLD DORSEY RD, APT 6, HARMANS			MD.					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY DISTRESS SYNDROME</u>										8hrs., 40min	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PREMATURITY</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>LIFANT OF DIABETIC MOTHER</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
NONE											
19a. DATE OF OPERATION			N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			N/A		
20a. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year			N/A					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			N/A			N/A					
22a. I certify that (I) (this hospital) attended the deceased from 7:30P 8 JULY 19 68, to 8:05P 8 JULY 68, that (I) (we) last saw the deceased alive on 8:05P.M. 8 JULY 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
HERBERT M. SOLOMAN, MAJ, MC,									9 JULY 1968		
22d. PHYSICIAN'S NAME (Type)			HERBERT M. SOLOMAN, MAJ, MC,			22e. ADDRESS			KIMBROUGH ARMY HOSP, FT MEADE, MARYLAND		
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			10 July 1968			Carl Baptist Cemetery			Carl Ga.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Singleton Funeral Home/Glen Burnie, Md.						JUL 10 1968			J Charles Judge		



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VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Dr. A. General</u>		d. STREET ADDRESS <u>Route 2</u>	
3 NAME OF DECEASED (Type or print) <u>Almira</u> First <u>Halloway</u> Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-1902</u> <u>EE</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hall</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>Arthur Hall Anna</u>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident (Thrombosis)</u> <u>4337</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2200</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/20/1968</u> to <u>7/20/1968</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>7/20/1968</u> , and that death occurred at <u>7/20/1968</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Richard E. Cook</u>		22b. DATE SIGNED <u>7/22/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>William Beese</u>		22d. ADDRESS <u>Ann</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-24-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake Memorial</u>	23d. LOCATION (City or town) (County) (State) <u>Chesapeake</u>
24. FUNERAL DIRECTOR <u>William Beese</u>		25a. REC'D BY REGISTRAR <u>JUL 23 1968</u>	



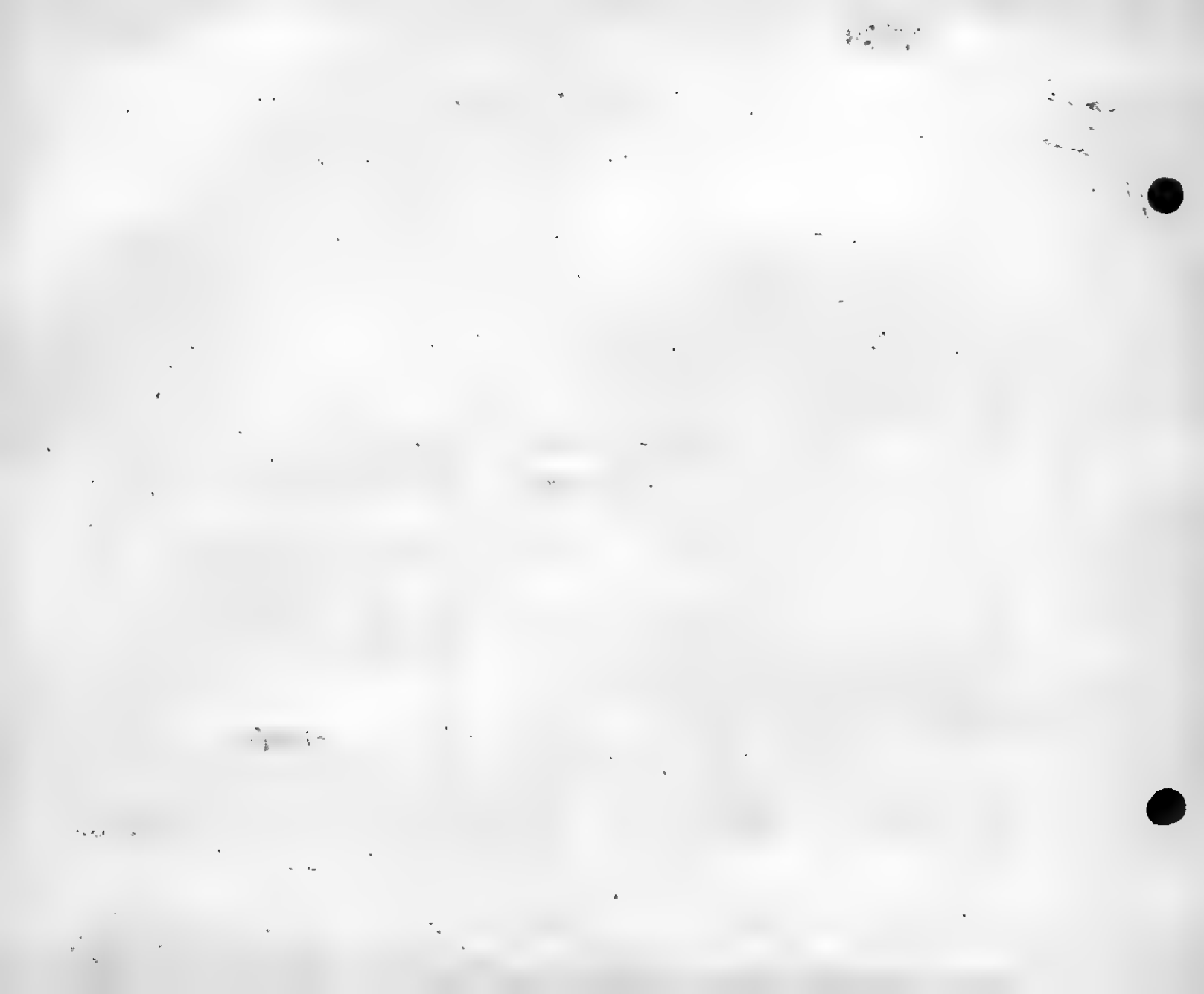
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

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MEDICAL CERTIFICATION

1 DECEASED NAME (Type or print) <i>Charles H. Halloway</i>			2a DATE OF DEATH <i>7-16-1968</i>			2b. HOUR <i>1:50 PM</i>			
3 SEX <i>Male</i>		4. RACE <i>Colored</i>		5. DATE OF BIRTH <i>12-23-1899</i>		6 AGE (In years last birthday) <i>68</i> YRS.		7 UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Alb.</i> Md.			
10 CITY OR TOWN OF DEATH <i>Edgewater</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Route 2</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>MD</i>		13b. COUNTY <i>Alb.</i>		13c. CITY OR TOWN <i>Edgewater</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>R. 2</i>	
14. FATHER'S NAME First Middle Last <i>Black Halloway</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Eliza Summers</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO <i>118-129150A</i>		17 INFORMANT <i>Alma Halloway</i> Address <i>Edgewater</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cancer of prostate with spread to retroperitoneum</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>spread to retroperitoneum</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>14 mo</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>4-3-67</i> , 19 <i>67</i> , to <i>7-16-68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-11-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>B. J. Allen</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>7-16-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>B. J. ALLEN</i>		22e. ADDRESS <i>62 Calhoun</i>							
23a. B. RIAL CREMATION, REMOVAL (Specify)		23b DATE <i>7-20-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cherry Hill</i>		23d. LOCATION (City or Town) <i>Chesapeake</i> (County) <i>MD</i> (State)			
24. FUNERAL DIRECTOR: <i>William Reese</i>		ADDRESS <i># Cherry Hill</i>		25a. REC'D BY REGISTRAR <i>JUL 19 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00379
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) AGNES ELEANOR GAST			2a. DATE OF DEATH Month July Day 17 Year 68			2b. HOUR M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH Nov. 28, 1910		6. AGE (in years lost birthday) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Co., Md.			
10. CITY OR TOWN OF DEATH Brooklyn Heights		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 920 First St.		12a. USUAL OCCUPATION (Kind of work done dur. ng most of work ng life, even if retired) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 920 First St.	
14. FATHER'S NAME First Marcellus Middle Evans Last Pearl			15. MOTHER'S MAIDEN NAME First Ogden Middle Ogden Last Ogden						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 213931-0746		17. INFORMANT Wilbur J. Gast (same)		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma colon & metastasis 1538 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to July , 19 68 , that (I) was last saw the deceased alive on 5-17 , 19 68 , and that in (my) own own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C.R. MacDonald MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-18-68			
22d. PHYSICIAN'S NAME (Type) C.R. MacDonald MD				22e. ADDRESS 325 Hospital Dr Elyria, Ohio 44024					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-20-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Ritchie Hgwy., A.A.Co., Md.			
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore				25a. REC'D BY REGISTRAR DAJUL 22 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <i>Ernest C. N. Georgi</i>			2a. DATE OF DEATH Month Day Year <i>7 16 68</i>			2b. HOUR <i>11:25</i> AM			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>6-29-07</i>		6. AGE (In years last birthday) <i>60</i> YRS.		7. UNDER YEAR MONTHS DAYS <i>11 11 11</i>	
7a. BIRTHPLACE (State or foreign country) <i>Penn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>North Annapolis Care Center</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Balto</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4215 Grace St. #21221</i>	
14. FATHER'S NAME First Middle Last <i>Oswald George</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna Fike</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>209-03-7570</i>		17. INFORMANT <i>Family</i>		Address <i>Same</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left ventricular failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic congestive failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>Months</i> <i>Years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
7									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>5/27, 1968</i> , to <i>7/16, 1968</i> , that (I) (we) last saw the deceased alive on <i>7/16, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Max C Frank</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/16/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>MAX C FRANK MD</i>		22e. ADDRESS <i>4215 Grace St. - Glen Burnie Md 21061</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 19, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Stone Church Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Finleyville, Pa</i>			
24. FUNERAL DIRECTOR <i>John H. Haas Funeral Home, 4200 Pennsylvania Ave</i>				ADDRESS <i>4200 Pennsylvania Ave</i>		25a. REC'D BY REGISTRAR <i>DATE JUL 17 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

09381

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09381

Item #2 Film GL03 8/6 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2b. HOUR	
CARLETTE		HORACE		GIBSON				7/29		1968		5:00 P. M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR		
male	negro	7/1/1915		53 YRS	MONTHS DAYS HOURS MIN				July 29, 1968		5:00 P. M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		U.S.A.				Anne Arundel County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Glen Burnie		North Arundel Hospital											
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Anne Arundel		Harmons		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Harmons, Maryland					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle Last	
Carl Gibson								Mary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
						Madalene Savage		2435 Dorton Ct. #30					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Multiple Injuries													
8147													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
8124													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				4:30 P.M. 7/29/68				pedestrian struck by car					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
				street				Anne Arundel, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				7/30/68					
Werner U. Spitz, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial				8/3/68		Mt. Auburn		Baltimore, Maryland					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles A. Rice				661 W. Barre St.				AUG 1 1968		Charles Judge			

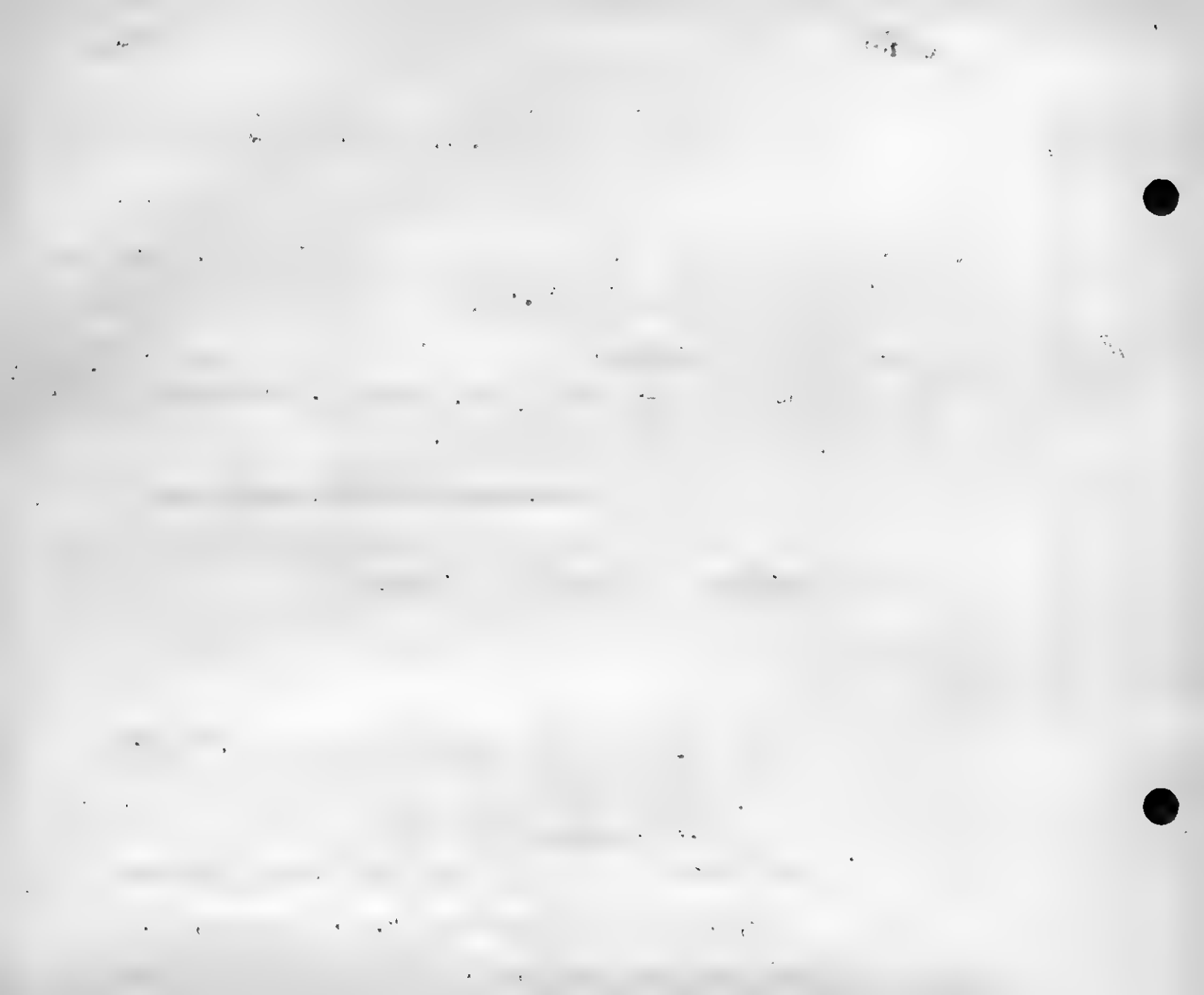
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate, and in any event, within 72 hours after death. The permit should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Mary			E.		Griffith	Month	Day	Year	M
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
female			white		January 25, 1980		88 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Glen Burnie, Md.			U. S. A.				Anne Arundel County Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie, Md.			North Arundel Hospital			housewife (ret.)		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md.			Anne Arundel		Severn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 2, Box 119
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Joshua					Stewart	Luice			Ward
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
No			None		215-50-3385-11 Mrs. Adelta V. Davis (Daughter) # 2		Same as		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>General Atherosclerosis</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Cholelithiasis, Chronic Uremia</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/29/1968</u> to <u>7/2/1968</u> , that (I) (we) last saw the deceased alive on <u>7/1/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<u>C. Dorkan</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		7/2/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
<u>C. Dorkan</u>						<u>321 Hosp. Drive, Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			July 7, 1968		Glen Haven Memorial Pk.		Glen Burnie, Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Robert P. Ware</u>						JUL - 5 1968		<u>Charles Judge</u>	
Singleton Funeral Home						Glen Burnie, Md.			

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year	
GEORGIA			E.		GROSS				2b HOUR P. M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR P. M.		
Female	White	1-5-XX 30	XXX38 YRS.			July 22 1968		10:10 P. M.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md		
Virginia		USA				Anne Arundel				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Davidsonville			Route 424 - Davidsonville			general clerk		prison hospital		
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Anne Arundel		Davidsonville				Route 424	
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
unknown									unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no			(If yes give war or dates of service)		724-48-1810		Carlos D. Gross - Davidsonville, Md.			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u>										
965X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOURS MIN.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			8:00 P.M. 7-22 19 68		Shot in head during argument					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
		Home		424 Etc.		Davidsonville, Anne Arundel, Md.				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)			Werner U. Spitz		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)		July 23, 1968	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
Burial		Jul. 26, 1968		Hillcrest Cemetery		Annapolis		A.A. Md.		
24 FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Beverley E. Hopping					DATE JUL 29 1968		J. Charles Judge			
Hopping Funeral Home - Annapolis, Md.										

FOR STATE HEALTH DEPT.

TO DEPUTY JUDICIAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00384		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH			
JAMES			J.		GROSS		2b HOUR			2c DATE KNOWN OF DEATH		
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7c MONTHS		7d DAYS	
Male			White		Oct. 1, 1921		46 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH		10 DATE PRONOUNCED DEAD	
Virginia			USA		WIDOWED		DIVORCED		Anne Arundel, Md		11 MONTH	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13a STREET AND NUMBER		13b COUNTY	
Annapolis			ANNE ARUNDEL GENERAL HOSP.		carpenter		construction		Route 424		Anne Arundel	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		13f COUNTY	
Md.			Anne Arundel		Davidsonville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 424		Anne Arundel	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		18 ADDRESS	
unknown			unknown		no		231-18-0535		Carlos D. Gross - Davidsonville, Md.		unknown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of chest												
DUE TO, OR AS A CONSEQUENCE OF (b)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
				8:00 PM 7-22 1968				Shot self in chest				
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				2a PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f LOCATION Street or R.F.D. No City or Town County State				
Home				Route 424 Davidsonville, Anne Arundel, Md.								
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER						
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
						ADDRESS (Street, city, town, or county)						
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		25a REC'D BY REGISTRAR		
Burial				Jul. 26, 1968		Hillcrest Memorial Cem.		Annapolis A.A. Md.		DATE JUL 29 1968		
24 FUNERAL DIRECTOR						25b REGISTRAR'S SIGNATURE						
Beverly L. Hopping						Charles Judge						
Hopping Funeral Home - Annapolis, Md.												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Hamilton			First Middle Last Hamilton			2a. DATE OF DEATH Month Day Year July 12 1968			2b. HOUR 9:10 AM
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 3, 1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 325 Cherry Lane
14. FATHER'S NAME Charles Hamlen			First Middle Last			15. MOTHER'S MAIDEN NAME Elizabeth Strutmen			First Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, none (unknown) No			16b. SOCIAL SECURITY NO.		17. INFORMANT Hamilton Teves 522 Rossiter Ave #12 Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21c. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-22</u> , 19 <u>68</u> , to <u>7-12</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>7-12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert Dabolin, M.D.</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <u>ROBERT DABOLIN, M.D.</u>					22e. ADDRESS <u>YOCRAIN HWY, NW GLEN BURNIE, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/15/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>AA Co Md</u>			
24. FUNERAL DIRECTOR <u>Mc Cully FH 237 Patuxent ave</u>					25a. REC'D BY REGISTRAR <u>JUL 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
10M REV 1768

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print) PAUL			First M Middle M Last HANTSKE			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 7 Day 2 Year 1968		2b HOUR 9:25 P		
3 SEX M	4 RACE W	5 DATE OF BIRTH 10-31-1914	6 AGE (In years last birthday) 53 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN 	2c DATE PRONOUNCED DEAD Month 7 Day 2 Year 1968		2d HOUR 9:25 P		
7a BIRTHPLACE (State or foreign country) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH HUNNE ARUNDEL				
10 CITY OR TOWN OF DEATH GLEN BURWIE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) N. ARUNDEL Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CIVIL SERVICE		12b KIND OF BUSINESS OR INDUSTRY RET.				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD.		13b COUNTY ANNAPOLIS		13c CITY OR TOWN ANNAPOLIS		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 223 FARRAGUT RD.		
14 FATHER'S NAME LEO			First C Middle HANTSKE Last BLANCH			15 MOTHER'S MAIDEN NAME PAEKIUSON			First Middle Last 	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give year or date of service) YES			16b. SOCIAL SECURITY NO WW #			17 INFORMANT EMILY B. HANTSKE			ADDRESS #13	
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4107 Myocardial Infarction										
DUE TO, OR AS A CONSEQUENCE OF (b) 										
DUE TO, OR AS A CONSEQUENCE OF (c) 										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE E. Linhardt		EXAMINER'S NAME (Type) E. LINHARDT		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 7-2-68		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county) ANNAPOLIS				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7-5-68		23c. NAME OF CEMETERY OR CREMATORY CEDAR BLVD		23d. LOCATION (City or Town) ANNAPOLIS		23e. COUNTY ANNAPOLIS		
24. FUNERAL DIRECTOR John M. Taylor		ADDRESS ANNAPOLIS, MD.		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE John Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 1 9387 </div>										
<div style="text-align: center;"> CERTIFICATE OF DEATH </div>										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
CARL LUTHER HOFFMAN						JULY 17, 1968		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		SEPT. 10, 1924		43 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				ANNE ARUNDEL Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
SEVERN			TELEGRAPH ROAD			FOREMAN		TOP CRAFT, INC.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ANNE ARUNDEL		SEVERN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		TELEGRAPH ROAD	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
CLARENCE HOFFMAN			ROSE BOWERS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
YES			217 18 8452		MRS. JULIA D. HOFFMAN (wife) Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Malignant Melemona right chest wall.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Anemia, Avitaminosis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
11-10-1966		Malignant Melanoma			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>10-13</u> , 19 <u>65</u> , to <u>7-17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
<u>Albert F. Cooper M.D.</u>		7-18-1968								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
Albert F. Cooper, M. D.		206 Crain Highway, S. W. Glen Burnie, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		JULY 20, 1968		FAHRNEY CEMETERY		SAN MAR, WASH. CO., MD.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
<u>E.B. Flannery</u>		SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND			JUL 23 1968 <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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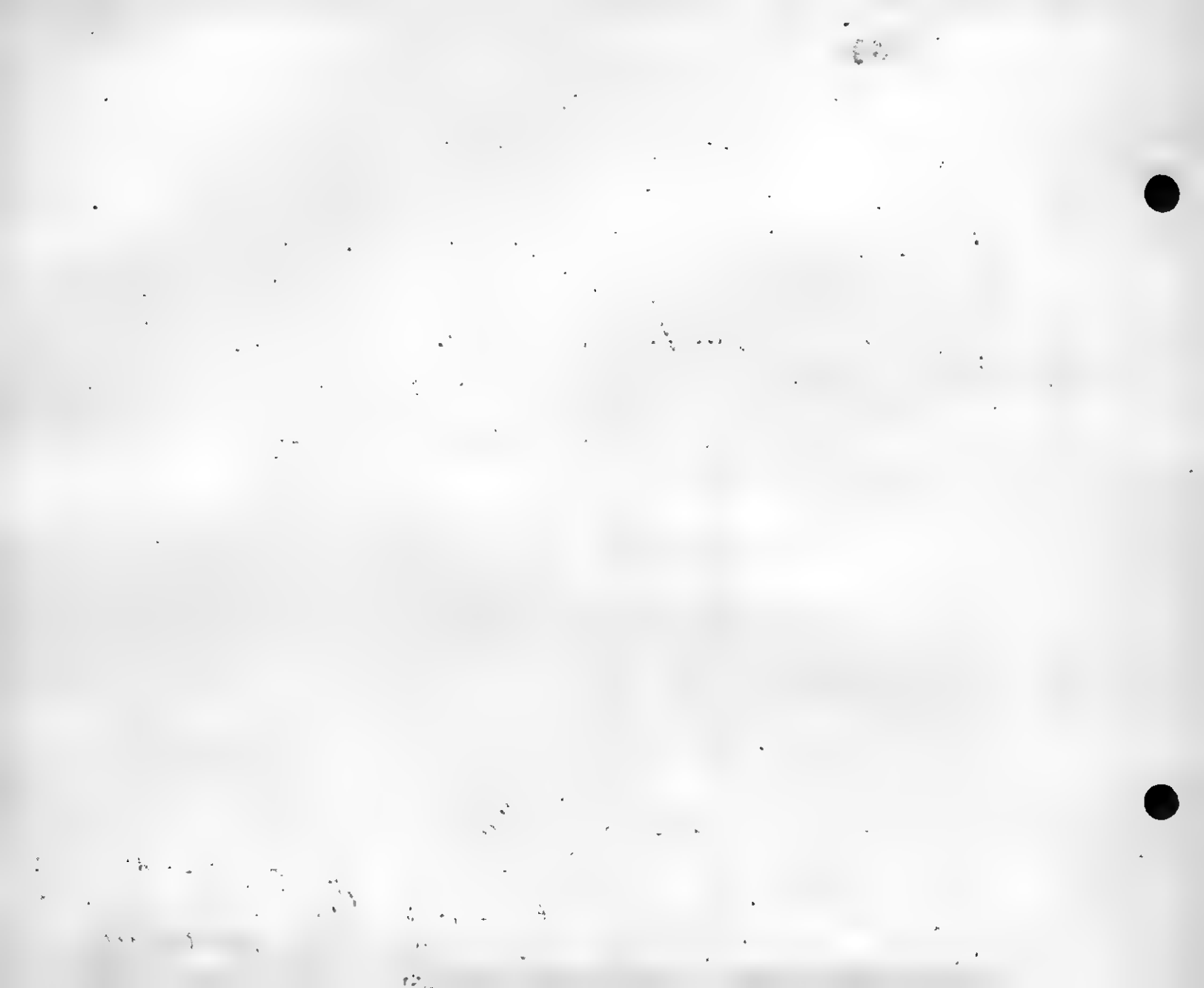
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3388

33280

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <u>John Holliday</u>			2a. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>68</u>			2b. HOUR M			
3. SEX <u>Male</u>		4. RACE <u>Colored</u>		5. DATE OF BIRTH <u>8/29/1890</u>		6. AGE (In years last birthday) <u>77</u> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>S.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Anne Arundel</u> Md.			
10. CITY OR TOWN OF DEATH <u>St. Margarets</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Bay Manor</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>U.D. Annapolis</u>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>137 O'Berry Ct.</u>			
14. FATHER'S NAME First Middle Last <u>James Holliday</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Lelia Tallard</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>214-05-0685A</u>		17. INFORMANT <u>Allice Holliday</u>		Address <u>Annapolis, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>355X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/20</u> , 19 <u>67</u> , to <u>7/29</u> , 19 <u>68</u> , that (I) (we) saw the deceased alive on <u>7/28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard I. Hochman, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/30/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>				22e. ADDRESS <u>16 Murray Ave, Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>8/1/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis U.D. Md.</u>			
24. FUNERAL DIRECTOR <u>William Reese, Jr. Annapolis, Md.</u>				ADDRESS		25. REC'D BY REGISTRAR <u>JUL 30 1968</u>		26. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

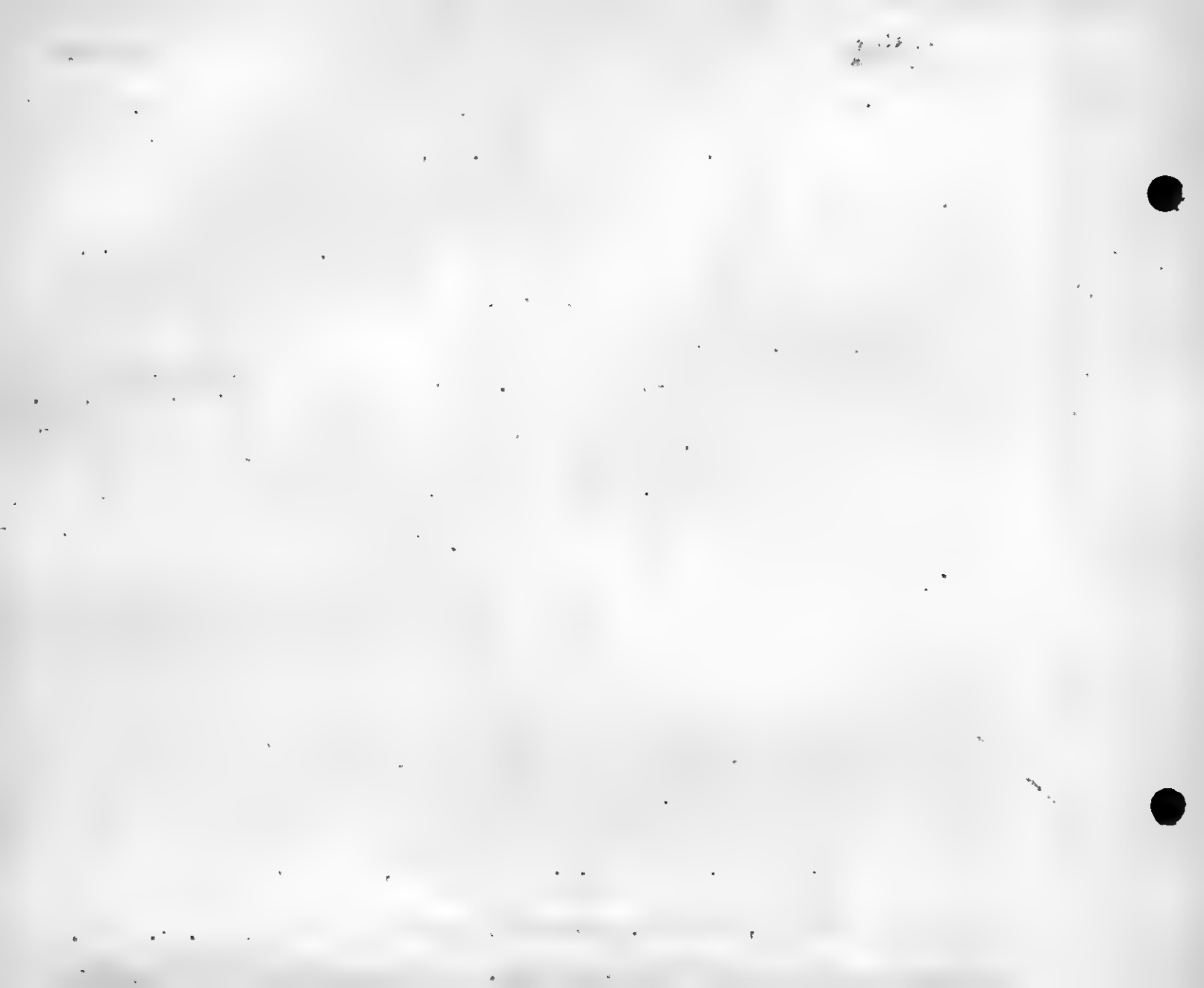
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 11 Film G402 8715756-11

CERTIFICATE OF DEATH

93389

1. DECEASED-NAME (Type or print) Averill			First Middle Last Angwin Hovermill			2a. DATE OF DEATH Month Day Year July 26 1968			2b. HOUR 11:54 AM		
3. SEX Male			4. RACE Cauc.			5. DATE OF BIRTH Mar. 16, 1906			6. AGE (In years last birthday) 62 YRS		
7a. BIRTHPLACE (State or foreign country) W. Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Lothian			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Tracys Lndg			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manager			12b. KIND OF BUSINESS OR INDUSTRY Farm		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Tracys Lndg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME Averill G. Hovermill			First Middle Last			15. MOTHER'S MAIDEN NAME Mary Largent			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 578-07-4397			17. INFORMANT Mrs. Lelia Hovermill			Address Tacaro Farms Tracys Landing, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) He had 3 previous heart attacks											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/26/68 , 19____, to 7/26/68 , 19____, that (I) (we) last saw the deceased, alive on 7/26/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles H. Wirth			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 7/28/68		
22d. PHYSICIAN'S NAME (Type) Charles H. Wirth, M.D.			22e. ADDRESS Lothian, Maryland 20820								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE July 29, 1968			23c. NAME OF CEMETERY OR CREMATORY St. James Chr. Cemetery			23d. LOCATION (City or Town) (County) (State) Lothian A. A. Md.		
24. FUNERAL DIRECTOR Hutchins Funeral Home			ADDRESS Owings, Md.			25a. RECD BY REGISTRAR JUL 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen on page 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Pages 5 and 6 should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First <i>Troun</i> Middle <i>B</i> Last <i>Howes</i>			2a DATE KNOWN OF DEATH			2b HOJR			
3 SEX <i>M</i>			4 RACE <i>W</i>		5 DATE OF BIRTH <i>5/21/14</i>		6 AGE (In years last birthday) <i>54</i> YRS		7 MONTHS <i>7</i> DAYS <i>28</i> HOURS <i>16</i> MIN		2c DATE PRONOUNCED DEAD Month <i>7</i> Day <i>28</i> Year <i>1968</i>	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b CITIZEN OF WHAT COUNTRY? <i>US</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Anne Arundel Co.</i>			
10 CITY OR TOWN OF DEATH <i>Annapolis</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Doon-Howe Memorial General</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>MD</i>			13b COUNTY <i>ARCE</i>			13c CITY OR TOWN <i>Annapolis</i>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME First <i>Robert M.</i> Middle <i>Howes</i> Last <i>Howes</i>			15 MOTHER'S MAIDEN NAME First <i>Leah R.</i> Middle <i>Howes</i> Last <i>Howes</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b SOCIAL SECURITY NO. <i>214-05-1498</i>			
17 INFORMANT <i>Mrs. Gladys C. Howes</i>			18 ADDRESS <i>5 Tyler Court.</i>			19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>			DUE TO, OR AS A CONSEQUENCE OF			CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) <i>Stroke</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No <i>19</i> City or Town <i>Annapolis</i> County <i>ARCE</i> State <i>Md.</i>						
22a I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			ACTUAL SIGNATURE <i>F. Linhardt</i> EXAMINER'S NAME (Type) <i>F. Linhardt</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED <i>7/28/68</i> ADDRESS (Street, city, town, or county) <i>A.A. Co.</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>July 31 1968</i>			23c NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i>			23d LOCATION (City or Town) <i>Annapolis</i> (County) <i>A.A.</i> (State) <i>Md.</i>			
24 FUNERAL DIRECTOR <i>Beall Funeral Home</i>			25a REC'D BY REGISTRAR <i>AUL 31 1968</i>			25b REGISTRAR'S SIGNATURE <i>John Charles Judge</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print) <i>Elsie</i>			First <i>Ireland</i>			Middle <i></i>			Last <i></i>			2a. DATE OF DEATH <i>7</i> Month <i>2</i> Day <i>68</i> Year <i>93</i> PM			
3 SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>May 9, 1882</i>			6 AGE (In years last birthday) <i>86</i> YRS.			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>US</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Anne Arundel</i> Md.						
10 CITY OR TOWN OF DEATH <i>Annapolis</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Anne Arundel</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b COUNTY <i>Anne Arundel</i>			13c CITY OR TOWN <i>Lothian</i>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER			
14 FATHER'S NAME First <i>Julius</i> Middle <i>E.</i> Last <i>Crandell</i>			15 MOTHER'S MAIDEN NAME First <i>Veturia</i> Middle <i></i> Last <i>Wayson</i>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			16b SOCIAL SECURITY NO. <i>214-36-8436</i>			17 INFORMANT Address <i>Mrs. Winterson Prout Lothian, Md. 20820</i>									
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)															
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several Months</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Heart Disease</i> <i>Years</i>															
(c) <i>Generalized Arteriosclerosis</i> <i>Years</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1300</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e PLACE OF INJURY (At home farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <i>6/30</i> , 19 <i>68</i> , to <i>July 2</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 2</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death															
22b SIGNATURE <i>Charles H. Wirth MD</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <i>7/3/68</i>						
22d PHYSICIAN'S NAME (Type) <i>CHARLES H. WIRTH, MD</i>			22e ADDRESS <i>LOTHIAN, MARYLAND 20820</i>												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b DATE <i>July 5, 1968</i>			23c NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Chr. Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Lothian Anne Arundel Md.</i>						
24. FUNERAL DIRECTOR <i>Hutchins Funeral Home</i>			ADDRESS <i>Owings, Md.</i>			25a REC'D BY REG. STRAR <i>Jul - 8 1968</i>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATE ON

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <i>Willie R JACKSON</i>					2a. DATE OF DEATH Month <i>July</i> Day <i>21</i> Year <i>1968</i>		2b. HOUR <i>5:15</i> P.M.		
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>October 15 1905</i>		6. AGE in years YRS. <i>62</i>		7. IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Charleston S.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.			
10. CITY OR TOWN OF DEATH <i>Crownsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Crownsville State Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>808 St Paul</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>JACKSON</i> Last <i>Letitia McCarry</i>			15. MOTHER'S MAIDEN NAME First <i>Letitia</i> Middle <i>McCarry</i> Last <i>McCarry</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>		(if yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>244-09-4034</i>		17. INFORMANT <i>Records - Crownsville State Hospital</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>4120</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal Shut Down</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive Cardiovascular Renal Disease</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>hypostatic pneumonia, decubitus ulcers</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/9/68</i> , 19 <i>68</i> , to <i>7/21/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7/21/68</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Lionel McHenry Mapp M.D.</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>7/21/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Lionel McHenry Mapp M.D.</i>				22e. ADDRESS <i>Crownsville State Hospital Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE <i>7-24-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Airy Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>			
24. FUNERAL DIRECTOR <i>E. J. Jones</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>JUL 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
Robert (NMI) James A.						Month Day Year		1968 5 15 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD	
M	N	5/5/52	16 YRS	— —		— —		Month Day Year 1968 7 11 6P. M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Lexington, M.C.		U. S. A.				Anne Arundel		Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Linthicum			River Rd off Nursery Rd			Student			
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY - M 15?	
Md			A. A. Co.					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Heroy Smith			Willie Mae James						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
No.						Mr. Julian McNair 1700 W. Nursery Rd			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7109									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Jumped into a hole of water in a gravel pit and could not swim (c)									a few minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			5:15 PM 7/11 1968		Accidental drowning in gravel pit				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or RFD No.		City or Town		County
			Gravel Pit		River Rd off Nursery Rd		Linthicum		Md
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Charles H. Wirth, M.D.						7/11/68			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
Charles H. Wirth, M.D.						Linthicum			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		7-13-68		Mt. Auburn Cem.		Baltimore		Md	
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Morton E. Dyett F.H.			1701 Laurens St			JUL 16 1968		Charles J. J...	

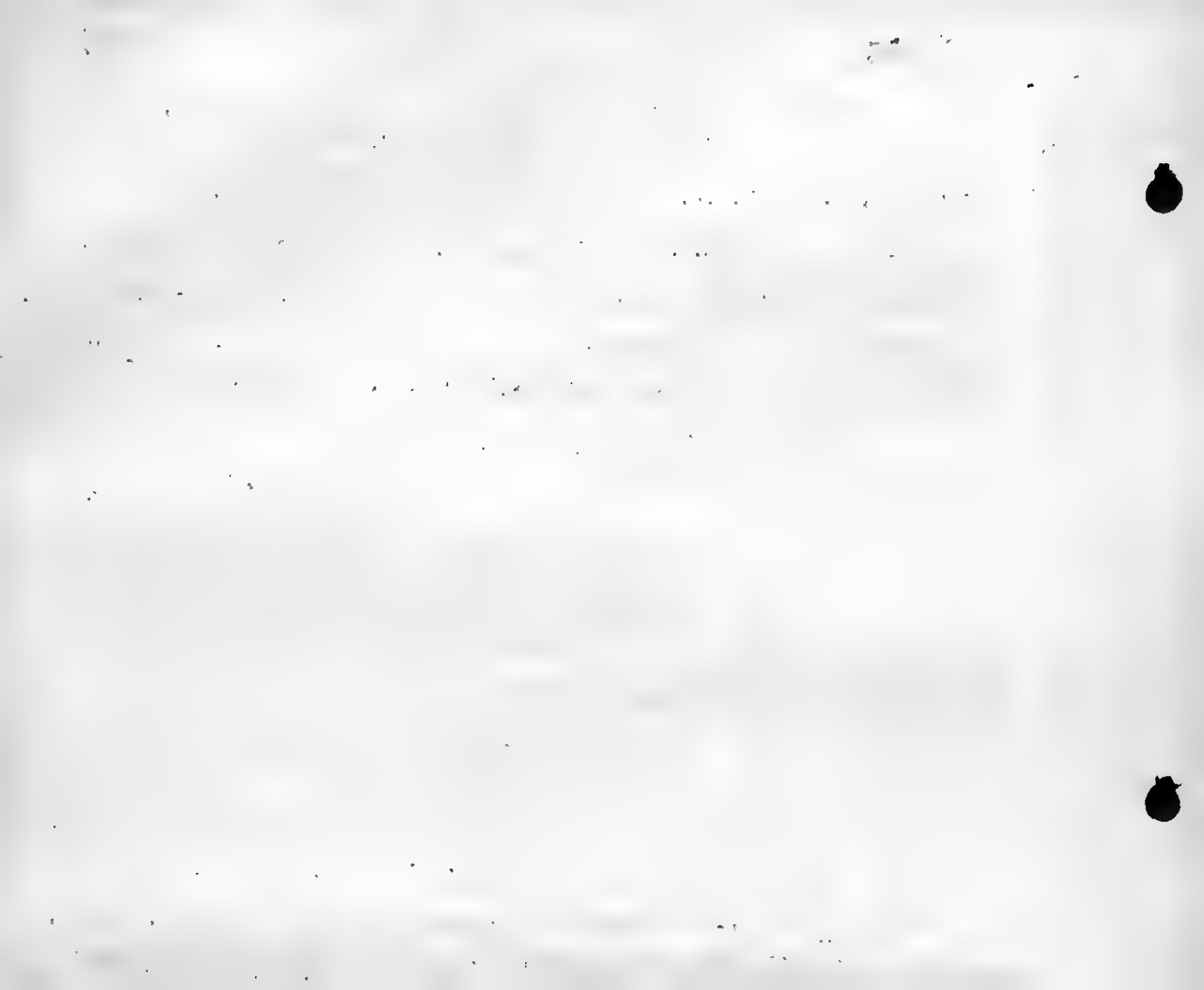


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First MAMIE Middle LOUISE Last JEFFREY			2a. DATE OF DEATH Month July Day 10, Year 1968		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH January 20, 1900		6. AGE (In years lost birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Hanover	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. #2 Box 63 Dorsey Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Hanover	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. #2 Box 63 Dorsey Rd.	
14. FATHER'S NAME First Middle Last Edward Slingman	15. MOTHER'S MAIDEN NAME First Middle Last Lilly A. Smith		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16b. SOCIAL SECURITY NO 215-50-0209		17. INFORMANT Address Mr. Richard M. Jeffrey (Husband) Same #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u> 1560 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary carcinoma of the Gall Bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1221 no					
19a. DATE OF OPERATION 1221	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Gall Bladder		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1966, to July 1968, that (I) (we) last saw the deceased alive on July 10 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. L. Smith MD		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED July 11, 1968		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 529 Camp Meade Rd., Lutherville, Md.			
23a. BURIAL CREMATION, REMOVAL, (Specify)	23b. DATE July 13, 1968	23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery	23d. LOCATION (City or Town) (County) (State) Anne Arundel Co. Maryland		
24. FUNERAL DIRECTOR Singleton Funeral Home	Glen Burnie, Md.		25a. REC'D BY REGISTRAR JUL 15 1968	25b. REGISTRAR'S SIGNATURE Charles J. J...	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 in the funeral director's possession. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files.

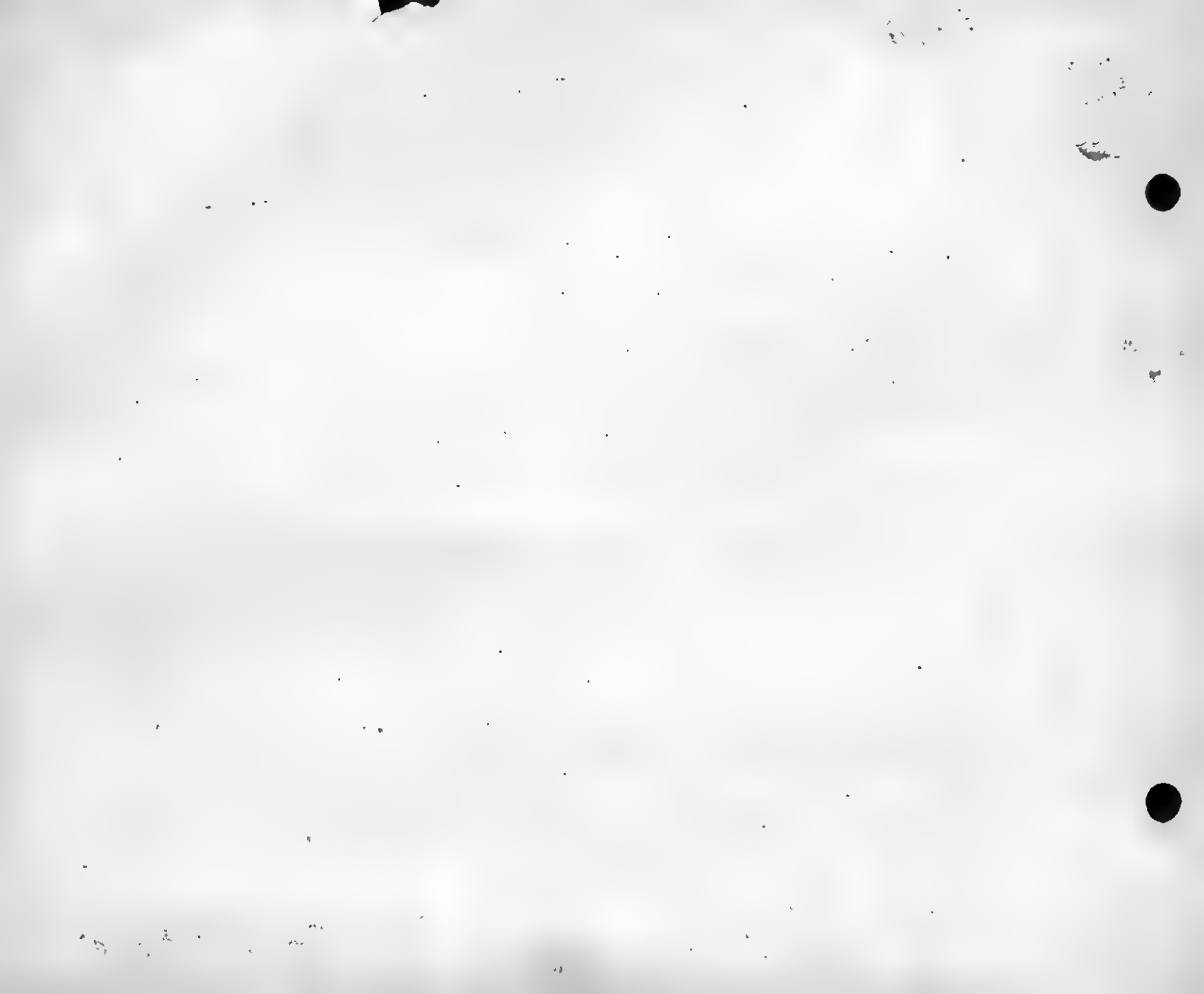
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER:
 necessary, please execute the certificate of death and return it to the funeral director. Page 4 should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with the Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 103887 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09395 </div> <h2 style="margin: 0;">MEDICAL EXAMINER'S CERTIFICATE OF DEATH</h2>											
1. DECEASED NAME (Type or Print) Clifton			First Johnson Jr.			Middle			Last		
2a. DATE KNOWN OF DEATH		EST <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		2b. HOUR P		7 17 1968					
3. SEX Male		4. RACE Col.		5. DATE OF BIRTH 3-13-1951		6. AGE (In years last birthday) 17 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.C. U.A. General			12a. OCCUPATION (Kind of work done during most of work ng life, even if retired) School Boy			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) MD.			13b. COUNTY A.A.			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME Clifton			First Johnson Jr.			Middle			Last		
15. MOTHER'S MAIDEN NAME Stenson			First Mary			Middle			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, if unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Clifton Johnson Jr.			ADDRESS St. 5 By 63 Anna MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shooting										Instant	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month Day Year HO-RAM 7-17 1968 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Runny Brawns Wrote			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Brawns Wrote				21f. LOCATION Street or R.F.D. No. City or Town County State St. 5 By 63 Anna MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E. Linhardt				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 7-17-68			
EXAMINER'S NAME (Type) E. Linhardt				ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) A.A.C.O.							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 7/20/68				23c. NAME OF CEMETERY OR CREMATORY Broad Neck			
24. FUNERAL DIRECTOR William Teese, Jr.				ADDRESS Anna, MD.				25. FILED BY 19 1968			
								25. FILED BY 19 1968			

MEDICAL CERTIFICATION

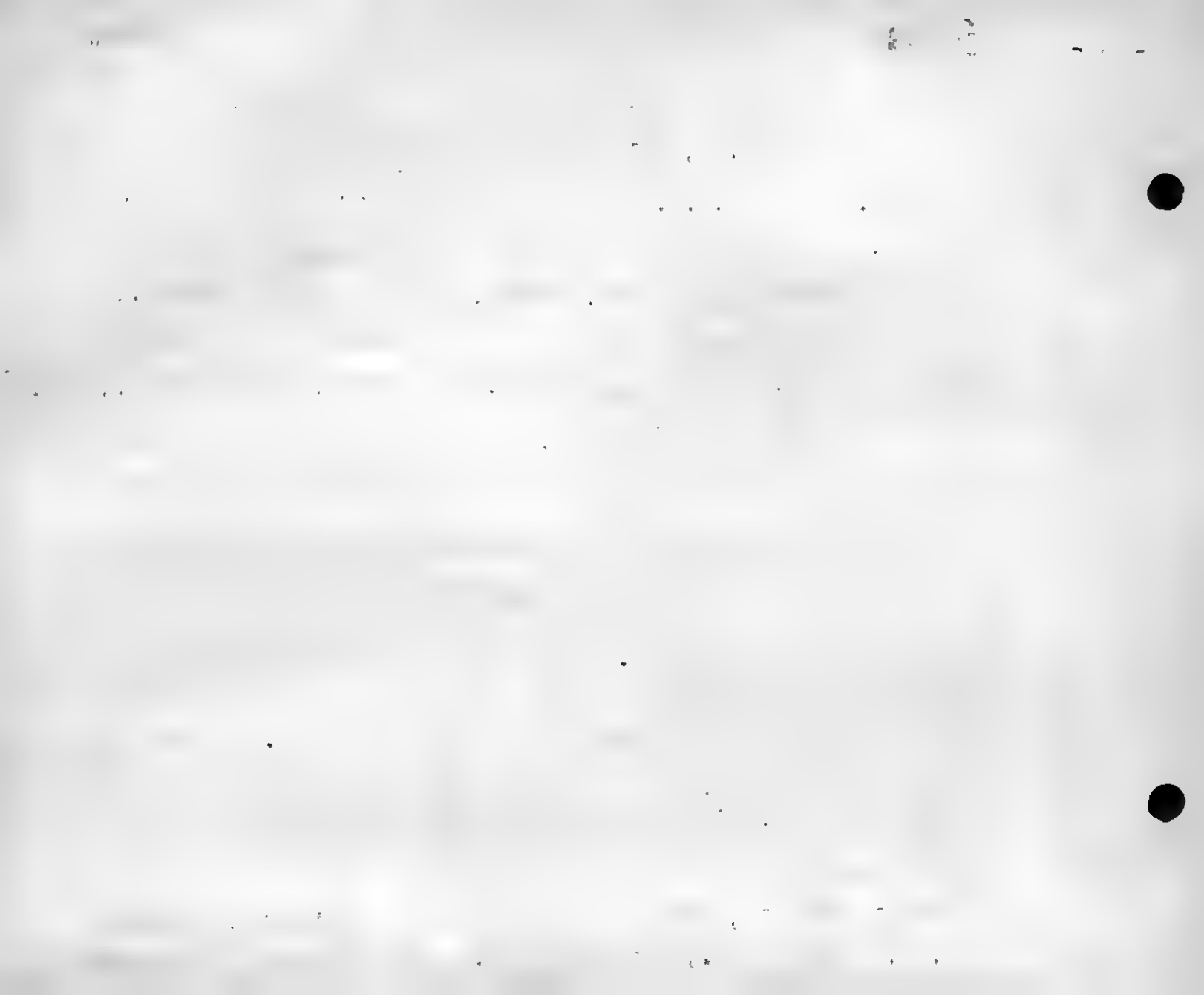


FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <i>Annice Belinda Johnson</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>7</i> Day <i>15</i> Year <i>68</i>			2b. HOUR <i>PM</i>			
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>Feb. 15, 1961</i>	6. AGE (in years last birthday) <i>7</i> YRS	7. UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	8. UNDER 24 HRS HOURS <i></i> MIN <i></i>	2c. DATE PRONOUNCED DEAD Month <i>7</i> Day <i>16</i> Year <i>68</i>		2d. HOUR <i>AM</i>	
7a. BIRTHPLACE (State or foreign country) <i>Tenn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>ANNE ARUNDEL COUNTY</i>			
10. CITY OR TOWN OF DEATH <i>Annapolis</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>D.O.C. - ANNE ARUNDEL GEN</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Student</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>School</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>Prince Geo.</i>			13b. CITY OR TOWN <i>Hyatts</i>		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13d. STREET AND NUMBER <i>5032 38th St.</i>		
14. FATHER'S NAME First <i>Victor Johnson</i> Middle <i></i> Last <i></i>				15. MOTHER'S M.A.D.E.N. NAME First <i>Ruth</i> Middle <i>Carter</i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Mrs. Ruth Carter</i> ADDRESS <i>Hyatts, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> <i>9100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>729</i>									
19a. DATE OF OPERATION <i>7-15-68</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Shedyside</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>HO. RAM</i>		21b. TIME OF INJURY Month, Day, Year <i>7-15-68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Swimming at Annapolis Beach</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <i>Annapolis Beach</i>		21f. LOCATION Street or RFD No <i>Shedyside</i> City or Town <i>PACON</i> County <i>ANNE ARUNDEL</i> State <i>MD</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. Linhardt</i>		EXAMINER'S NAME (Type) <i>E. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county) <i>MA CO</i>		22b. DATE SIGNED <i>7-16-68</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 19, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Washington National</i>		23d. LOCATION (City or Town) <i>Suitland</i> (County) <i>Maryland</i> (State) <i></i>			
24. FUNERAL DIRECTOR <i>W. W. CHAMBERS CO., Riverdale, Md.</i>				25a. REC'D BY REG. STRAR <i>JUL 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Maggie Johnson						7-17-1968		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		Colored		2-29-1891		77 YRS.		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md		U.S.A.				Annapolis Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			61 Collegeck. Tenad			Cook				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Annapolis		Annapolis		YES		61 Collegeck. Tenad	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Jacob Wright			Elizabeth Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
			215-322728		Annie Spencer		Annapolis Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-vascular Accident									3 wks.	
4120 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Dis.									at least	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertensive Cardiovascular									8 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
445X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
				219/60 68						
22a. I certify that (I) (this hospital) attended the deceased from 7-17-1968, to 7-17-1968, that (I) (we) last saw the deceased alive on 7-17-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Faye W. Allen					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-18-68			
22d. PHYSICIAN'S NAME (Type) Faye W. Allen					22e. ADDRESS 62 Cathedral ST					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-22-68		23c. NAME OF CEMETERY OR CREMATORY Broadneck		23d. LOCATION (City or Town) (County) (State)				
Burial						Shiloh Md				
24. FUNERAL DIRECTOR William Reese #111111					25a. REC'D BY REGISTRAR JUL 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>William Johnson</i>		2a. DATE OF DEATH Month <i>7</i> Day <i>26</i> Year <i>1968</i>		2b. HOUR <i>4:30</i> PM
3. SEX <i>Male</i>	4. RACE <i>Colored</i>	5. DATE OF BIRTH <i>5-14-1914</i>	6. AGE (In years last birthday) <i>54</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN <i></i>
7a. BIRTHPLACE (State or foreign country) <i>Ind.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Ala.</i>	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>A. A. General Construction</i>	12a. USUAL OCCUPATION (Kind of work done during last 12 months) <i>Construction</i>	12b. KIND OF BUSINESS OR INDUSTRY <i></i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <i>Ind.</i>	13b. COUNTY <i>Ala.</i>	13c. CITY OR TOWN <i>Ann.</i>	13d. INSIDE CITY, IN TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1812 popular ave</i>
14. FATHER'S NAME First <i>George</i> Middle <i>Johnson</i> Last <i>Washington</i>	15. MOTHER'S MAIDEN NAME First <i>Rebecca</i> Middle <i>Washington</i> Last <i>Washington</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO <i>212-18-773</i>	17. INFORMANT <i>Novella Johnson Ann.</i>		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary TB</i> DUE TO, OR AS A CONSEQUENCE OF <i>far advanced</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF <i></i> (c) <i></i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>about 10 weeks</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No <i>4-14-68</i> City or Town <i>7-25-68</i> County <i></i> State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>4-14-68</i> , 19 <i></i> , to <i>7-25-68</i> , 19 <i></i> , that (I) (we) last saw the deceased alive on <i>7-24-68</i> , 19 <i></i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>A. T. Allen</i>		DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>		22e. ADDRESS <i>62 CATHERINE ST</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>7-29-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Pine Lawn</i>		23d. LOCATION (City or Town) (County) (State) <i>Annapolis Md.</i>
24. FUNERAL DIRECTOR <i>William Reese</i>		25a. REC'D BY REGISTRAR <i>JUL 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in page 1 in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First <u>Robert</u> Middle <u>W.</u> Last <u>Jones</u>			2a DATE KNOWN OF DEATH			Month <u>7</u> Day <u>19</u> Year <u>68</u>		2b HOUR <u>A</u>	
3 SEX <u>M</u>	4 RACE <u>W</u>	5 DATE OF BIRTH <u>7-29-04</u>	6 AGE (In years last birthday) <u>63</u> YRS	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>	IF UNDER 24 HRS HOURS <u></u> MIN <u></u>	2c DATE PRONOUNCED DEAD			Month <u>7</u> Day <u>19</u> Year <u>68</u>		2d HOUR <u>A</u>	
7a BIRTHPLACE (State or foreign country) <u>MD.</u>			7b CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>AACO</u>			
10 CITY OR TOWN OF DEATH <u>Glen Burnie</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WALTER A. ARONDEL</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>DEALER</u>			12b KIND OF BUSINESS OR INDUSTRY <u>POULTRY</u>			
13a USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE <u>MD</u>			13b COUNTY <u>A.A. Co</u>			13c CITY OR TOWN <u>RIVERA BEACH</u>			13e STREET AND NUMBER <u>8565 Bay Road</u>			
14. FATHER'S NAME			First <u>CHARLES N.</u> Middle <u></u> Last <u>JONES</u>			15. MOTHER'S MAIDEN NAME			First <u>CORA ELIZABETH</u> Middle <u></u> Last <u>ECKERT</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16b SOCIAL SECURITY NO. <u>217-32-7697</u>			17. INFORMANT			ADDRESS <u>MRS DORIS A JONES ANNAPOLIS, MD</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic disease</u> <u>4407</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>broken</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M. <u></u>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.			City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>[Signature]</u>			EXAMINER'S NAME (Type) <u>E. Linhardt</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>7-19-68</u> <u>AACO</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b DATE <u>7/22/68</u>			23c NAME OF CEMETERY OR CREMATORY <u>LODGE PARK CEM</u>			23d LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD</u>			
24. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>						ADDRESS <u>715 LIGHT ST</u>			25a REC'D BY REGISTRAR <u>JUL 23 1968</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



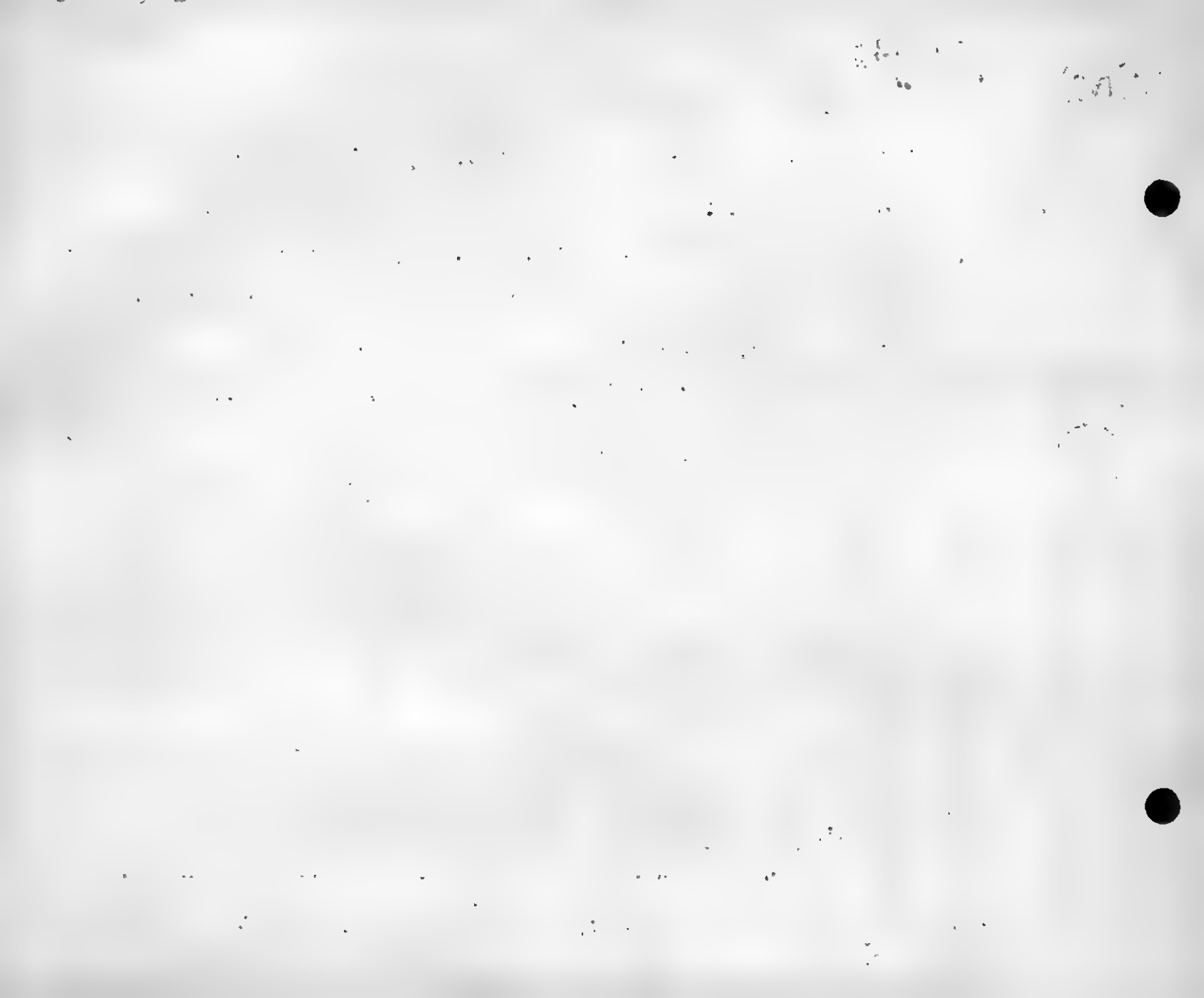
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
William Edward JONES						July 22 1968			6:25 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
Male		White		Sept. 15, 1891		76 YRS.		MONTHS DAYS HOURS M.N.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel Gen. Hosp.			SHEET METAL		TINNER		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP?		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		819 Boucher Ave.,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
WM EDWARD BENJAMIN JONES			LAURA V. WOODEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
NO			21309 8987		Olivia D. JONES #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1. NATATION</u>									2 WKS	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF ESOPHAGUS</u>									6 MOS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 19, 1968</u> , to <u>JULY 22, 1968</u> , that (I) (we) last saw the deceased alive on <u>24 July 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Edward S. Beck</u>									<u>7/22/68</u>	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Edward S. Beck, M.D.					73 Franklin St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
BURIAL		7-24-68		GLEN HAVEN CEMT.		GLEN BURNIE		A.H. MD.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John M. Lyons Annapolis, Md.					DATE JUL 23 1968		Charles Judge			

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

09401

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
BEATRICE				KATCEF	Month Day Year July 11 1968		M	
3. SEX	4 RACE	5 DATE OF BIRTH			6 AGE (In years last birthday)	7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.
female	white	Oct. 11, 1918			49 YRS.	MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	USA			Anne Arundel Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		1200 Poplar St.			house wife		own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland		Anne Arundel	Annapolis	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1200 Poplar Ave.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Abram Berman					Anna			Weinstein
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT				
no		UNKNOWN		Leon Katcef - same as #13 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a)								
DUE TO, OR AS A CONSEQUENCE OF								
Carcinoma of Stomach								
(b)								
c. Gen. Carcinomatosis								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
5/28/68		G.I. distress			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6/23, 1968 to 7/11, 1968, that (I) (we) last saw the deceased alive on 7/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
M. F. Klawans, MD				<input checked="" type="checkbox"/>				7/11/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
M. F. Klawans, MD		31 SOUTH GATE AVE						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Jul. 12, 1968	Kneseth Israel Cemetery		Annapolis			Md.
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Beverley E. Hopping		JUL 16 1968		J. Charles Judge				
HOPPING FUNERAL HOME - Annapolis, Md.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



5

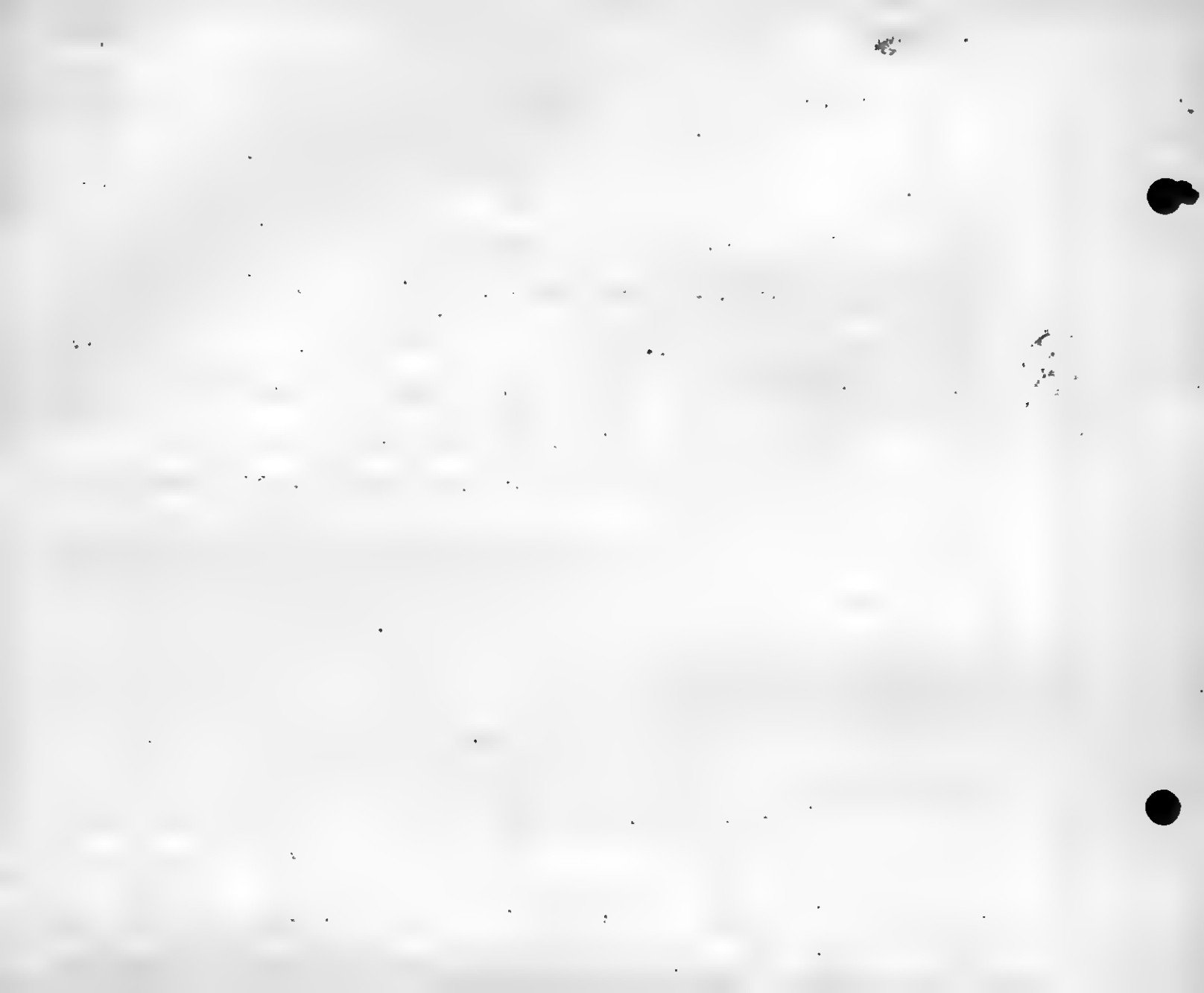
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) George B. Keester			2a. DATE OF DEATH Month July Day 13 Year 1968			2b. HOUR A M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH 1-6-1887		6. AGE (in years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Mo.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Annapolis Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life. Was it retired?) Naval Officer		12b. KIND OF BUSINESS OR INDUSTRY Navy			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Mo.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 110 Gloucester St.	
14. FATHER'S NAME First Middle Last JAMES H. KEESTER			15. MOTHER'S M maiden name, First Middle Last ADELAIDE WILKES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown (If yes give year and dates of service) Yes		16b. SOCIAL SECURITY NO WDI-11		17. INFORMANT MARY ELLEN KEESTER		Address #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Hardening Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Hardening DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July , 19 58 , to 7-13 , 19 68 , that (I) (we) last saw the deceased alive on 7-7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W.M. P. Stephens				22c. DATE SIGNED 7-13-68		22d. ADDRESS 38 Cornhill St. Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-15-68		23c. NAME OF CEMETERY OR CREMATORY St. Anne's		23d. LOCATION (City or Town) (County) (State) Annapolis A.P. Md.			
24. FUNERAL DIRECTOR John M. Loxton				25a. REC'D BY REGISTRAR JUL 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

09995

00408

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) CHARLES		First WARREN	Middle KELLERHOUSE, JR.	2a. DATE OF DEATH Month JULY Day 17 Year 68	2b. HOUR 2010 M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 19 SEPT 67	6. AGE (In years last birthday) YRS. 10	IF UNDER 1 YEAR MONTHS 10 DAYS	IF UNDER 24 HRS HOURS 10 MIN.
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ANNE ARUNDEL Md.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. NAVAL HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE MD.	13b. COUNTY A.A. Co.	13c. CITY OR TOWN SELEDA PARK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. #1 Box 36	
14. FATHER'S NAME CHARLES	First W. KELLERHOUSE	Middle MARY	15. MOTHER'S MAIDEN NAME STOWERS	16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	
16b. SOCIAL SECURITY NO.		17. INFORMANT C. WARREN KELLERHOUSE SR. #13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACCIDENTAL DROWNING 710.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 929.7					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from DOA , 19____, to____, 19____, that (I) (we) lost saw the deceased alive on____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. S. Stone		DEGREE LCDR MC USN	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 11 JULY 68	
22d. PHYSICIAN'S NAME (Type) R. S. STONE, LCDR MC USN		22e. ADDRESS NH, ANNAPOLIS, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-15-68	23c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL CEMT.	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.A. MD.		
24. FUNERAL DIRECTOR John M. Lytton Sons		ADDRESS Annapolis, Md.	25a. REC'D BY REGISTRAR JUL 16 1968	25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) JOHN A. KINDIG			First Middle Last		2a. DATE OF DEATH Month July Day 14 Year 1968			2b. HOUR 1820 M	
3 SEX MALE		4. RACE CAU (White)		5 DATE OF BIRTH MARCH 16, 1912		6 AGE (in years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Adams Co., Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Laurel, Ft. Geo. G. Meade		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) Kimbrough AH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NSA		12b. KIND OF BUSINESS OR INDUSTRY USA			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm-ssion) STATE MD COUNTY Prince Georges		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1055 Marton St			
14 FATHER'S NAME First Albert Middle H. Last Kindig Deceased				15. MOTHER'S MAIDEN NAME First Annie Middle Fisher Last Deceased					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, 30 yrs Army (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 180-03-2352		17. INFORMANT Address Acile P. Tunnell 1055 Marton St, Laurel, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15-20 min. 5 years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 14 Jul, 1968 , to 14 Jul, 1968 , that (I) (we) last saw the deceased alive on DOA 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John W. Barnard				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 14 July 68			
22d. PHYSICIAN'S NAME (Type) JOHN W. BARNARD CPT, MC				22e. ADDRESS US Kimbrough Army Hospital FGCM, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City or Town) (County) (State) Littlestown, Adams Co., Pa.			
24. FUNERAL DIRECTOR Richard A. Little		ADDRESS 530 WASH BLVD		25a. RECD BY REGISTRAR DAN		25b. REGISTRAR'S SIGNATURE James Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

39397

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09405

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) DAVID		First DAVID	Middle ALAN	Last KNOWLES	2a. DATE OF DEATH JULY Month 19 Day 1968 Year		2b. HOUR 10:55 MIN M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 18 July 1968		6. AGE (In years last birthday) YRS		IF UNDER 1 YEAR MONTHS 1 DAYS 1
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Fort Geo G. Meade		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Kimbrough Army Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Miklasz, Apt #6
14. FATHER'S NAME Charles C. Knowles		First Charles	Middle C.	Last Knowles	15. MOTHER'S MAIDEN NAME Mary Eileen Travis		First Mary	Middle Eileen Last Travis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) N/A		16b. SOCIAL SECURITY NO N/A		17. INFORMANT Mrs. Mary E. Knowles, same as Item #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extreme Prematurity DUE TO, OR AS A CONSEQUENCE OF (b) Amnionitis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One Day
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (he) (this hospital) attended the deceased from 18 July , 19 68 , to 19 July , 19 68 that (he) (we) last saw the deceased alive on 19 July , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.								
22b. SIGNATURE Joseph H. Wearn M.D.		22c. DEGREE DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. DATE SIGNED 19 July 1968		
22d. PHYSICIAN'S NAME (Type) JOSEPH H. WEARN, CPT, MC		22e. ADDRESS U.S. KIMBROUGH ARMY HOSP, FT MEADE, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 24, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) Glen Burnie, Maryland		(County) (State)
24. FUNERAL DIRECTOR E. B. Fleming		ADDRESS Singleton Funeral Home		25a. REC'D BY REGISTRAR JUL 25 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

199998

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

99406

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
BELL				KORSUNSKY	July 31 68		430 PM	
3. SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS A.M.	
FEMALE	WHITE		MARCH 13, 1884		84 YRS			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
RUSSIA	U.S.A.				ANNE ARUNDEL			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
ANNAPOLIS	BAY MANOR NURSING HOME		HOUSEWIFE		AT HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND	ANNAPOLIS		YES <input type="checkbox"/> NO <input type="checkbox"/>		38 MARYLAND AVENUE			
14 FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT	
ISRAEL PUSHKIN	GUSSIE		NO				MR. ARTHUR KORSUNSKY, 169 KING GEORGE STREET, ANNAPOLIS, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 232X (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CORONARY ARTERY DISEASE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 10 YEARS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
2 d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from 7/20, 1968, to 31 July, 1968, that (2) (we) lost saw the deceased alive on 20 July 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Edward S. Bede MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/31/68		
22d. PHYSICIAN'S NAME (Type) EDWARD S. BEDE				22e. ADDRESS ANNAPOLIS, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		8-2-68		WORKMEN CIRCLE		BALTIMORE, MARYLAND		
24 FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				DATE AUG 2 1968		Charles Judge		

REDE
URKNEI
21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

39393

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

39407

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Mintie Kyler</u>			2a. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>68</u>			2b. HOUR <u>9:15</u> M	
3. SEX <u>Female</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH <u>1888</u>		6. AGE (In years last birthday) <u>80</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Anne Arundel</u> Md.	
10. CITY OR TOWN OF DEATH <u>Crownsville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Crownsville State Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>2530 N. Ellamont Street</u>		14. FATHER'S NAME First Middle Last <u>unknown</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>unknown</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO <u>unknown</u>		17. INFORMANT Address <u>records - Crownsville State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4129</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic cardio-vascular disease</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Senility</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>48</u> , to <u>7/24</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>7/24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Hildagarde Heard Reissman</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/24/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Hildagarde Heard Reissman</u>				22e. ADDRESS <u>Crownsville State Hospital, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-29-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Youngs Ch.Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Huntingtown Cal. Md</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Anthony E. Savelle Prince Frederick Md</u>				25a. REC'D BY REGISTRAR <u>DAUL 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

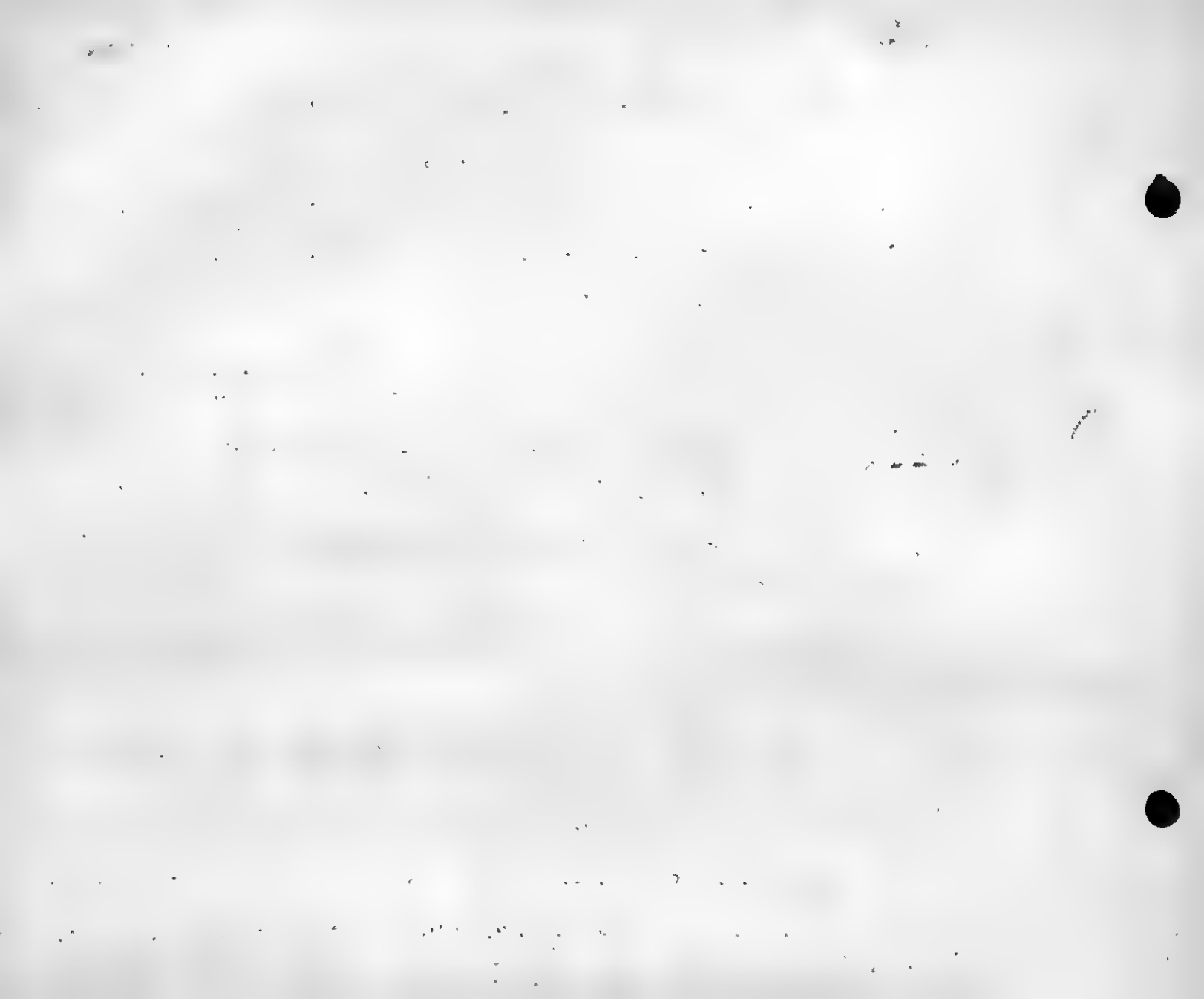
39400

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

39408

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR AM		
William Peter LAUN						July 26, 1968			10:00		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
male		white		Sept. 1, 1884		83 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel County, Md.					
New Jersey		USA									
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel General			Linotype operator			newspaper		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel			Crownsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 2 Box 513	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John Laun			Mary								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT					
no			578-09-9553			4909 Edmondson Ave., Albert Laun - Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septis - Urinary tract infection</u> 1530 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rt. renal obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>1 year</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Cecum</u> APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 1/2 year</u> <u>1 year</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Marked Anemia</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (At home, farm, street, factory, office building etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1968</u> to <u>July 26, 1968</u> , that (I) (we) lost saw the deceased alive on <u>July 26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Peter F. Verkouw MD</u>						DEGREE MD		22c ADDRESS 1407 Forest Drive, Annapolis, Md.		22d DATE SIGNED 7/26/68	
22d. PHYSICIAN'S NAME (Type)											
Peter F. Verkouw, M. D.											
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Jul. 29, 1968			Our Lady of the Fields			Millersville, Md.		
24 FUNERAL DIRECTOR E. Hopping						25a. REC'D BY REGISTRAR JUL 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			
HOPPING FUNERAL HOME - Annapolis, Md.											



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

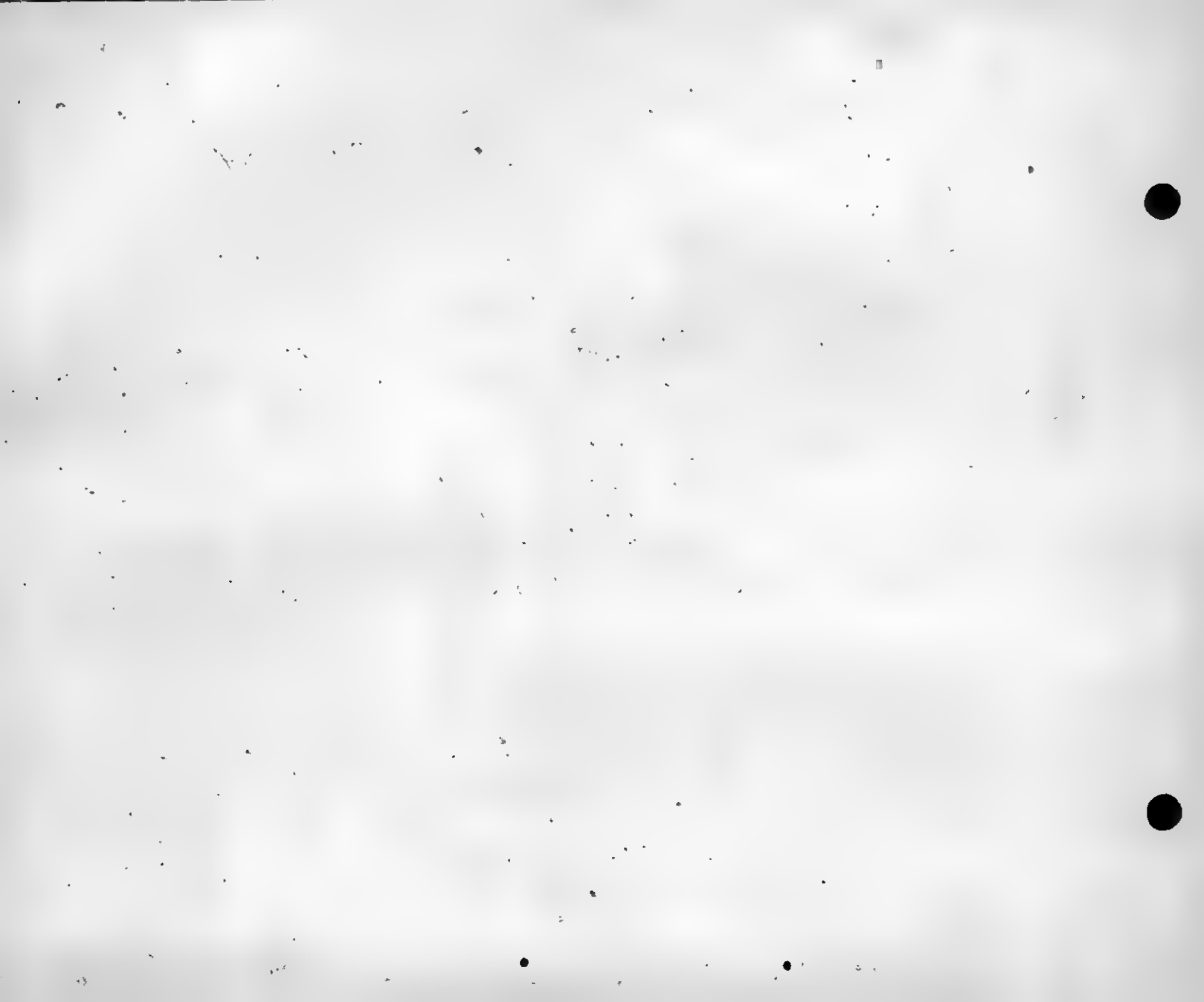
VR A1SME (5)
10M REV 1/68

1. DECEASED-NAME (Type or Print)		First <i>Edith</i>		Middle <i>Rita</i>		Last <i>Lawrence</i>		2a. DATE KNOWN OF DEATH		Month <input checked="" type="checkbox"/> 7		Day <i>17</i>		Year <i>68</i>		2b. HOUR		<i>P</i>			
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>MAY 26, 1914</i>		6. AGE (in years) <i>54</i> YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____		2c. DATE PRONOUNCED DEAD Month <i>7</i> Day <i>17</i> Year <i>68</i>		2d. HOUR		<i>P</i>					
7a. BIRTHPLACE (State or foreign country) <i>MD</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Anne Arundel, general</i>				Md.					
10. CITY OR TOWN OF DEATH <i>Annapolis</i>				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Dom. Anne Arundel, gen</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>HOUSEWIFE</i>				12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>MD</i>				13b. COUNTY <i>ANNO.</i>				13c. CITY OR TOWN <i>Cape St. Clair</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Box 226 - E - Rt 4</i>							
14. FATHER'S NAME First <i>MORRIS</i> Middle <i>HUSBAND</i> Last _____				15. MOTHER'S MAIDEN NAME First <i>BERTHA</i> Middle <i>PERRYMAN</i> Last _____																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> no, or unknown)				16b. SOCIAL SECURITY NO. <i>?</i>				17. INFORMANT <i>J. F. LAWRENCE SR. Rt 4 Box 226C ANNAPOLIS, MD</i>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cause Chance</i> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1. 4. 7</i>																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <i>[Signature]</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <i>7/17/68</i>					
EXAMINER'S NAME (Type) <i>E. L. H. HOFF</i>				ADDRESS (Street, city, town, or county) <i>[Address]</i>																	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>7:20/68</i>				23c. NAME OF CEMETERY OR CREMATORY <i>ST. MARYS</i>				23d. LOCATION (City or Town) (County) (State) <i>ANNAPOLIS ANN MD</i>									
24. FUNERAL DIRECTOR <i>HARDESTY FUNERAL HOME</i>				ADDRESS <i>ANNAPOLIS, MD</i>				25a. REC'D BY REGISTRAR DATE <i>JUL 22 1968</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

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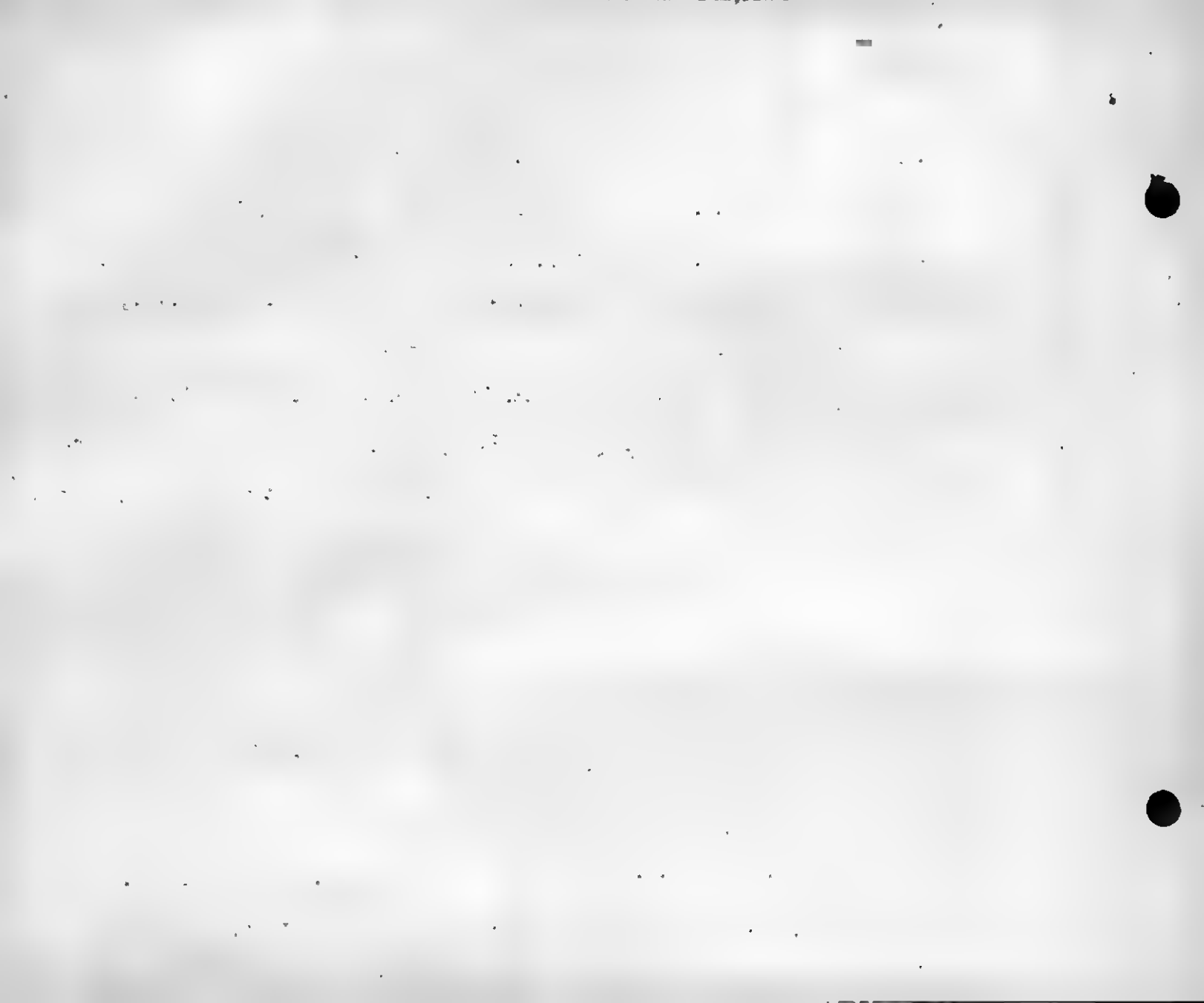
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) Emma First Payne Middle LAWSON Last			2a. DATE OF DEATH Month July Day 25 Year 1968			2b. HOUR 10:15 PM					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH October 26th 1880		6. AGE (in years) YRS 87		IF UNDER 1 YEAR MONTHS 8 DAYS 15		IF UNDER 24 HRS HOURS 10 MIN 15	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.					
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital		12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired) Chamberlain		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Wetmore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 25			
14. FATHER'S NAME First Robert Middle Treat Last Treat			15. MOTHER'S MAIDEN NAME First Lutricia Middle Ellis Last Ellis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 529-01-9201		17. INFORMANT Records - Crownsville State Hospital, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF Decubitus Ulcers (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Hypertension (c) Arteriosclerosis - Generalized and Cerebral; Pneumonia - Hypostatic										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 15 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5/12/68 , 19 68 , to 7/25/68 , 19 68 , that (I) (we) last saw the deceased alive on 7/25/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.											
22b. SIGNATURE Lionel M. Henry, M.D.		22c. DATE SIGNED 7/25/68		22d. PHYSICIAN'S NAME (Type) Lionel M. Henry, M.D.		22e. ADDRESS Crownsville State Hospital, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 7/29/68		23c. NAME OF CEMETERY OR CREMATORY Flint Hill		23d. LOCATION (City or Town) (County) (State) Oakton Fairfax, VA.					
24. FUNERAL DIRECTOR Everly Funeral Home		ADDRESS 10565 Main Street		25a. REC'D BY REGISTRAR JUL 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Ida			First Middle Last			2a. DATE OF DEATH Month July Day 11 Year 1968		2b. HOUR P. 7:40 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH February 15, 1893		6. AGE (In years last birthday) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Anne Arundel Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 38 Maryland Ave.,	
14. FATHER'S NAME First Middle Last Israel Pushkin			15. MOTHER'S MAIDEN NAME First Middle Last Gussie Stam						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. No		17. INFORMANT Address Mr. Irvin Pushkin 2022 Park Avenue 21217					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) UNKNOWN								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 1 DAY	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/11, 1968 , to 7/11, 1968 , that (I) (we) lost saw the deceased alive on 7/11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Edward S. Beck				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/12/68			
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.				22e. ADDRESS 73 Franklin St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/14/1968		23c. NAME OF CEMETERY OR CREMATORY Workmen Circle		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road				25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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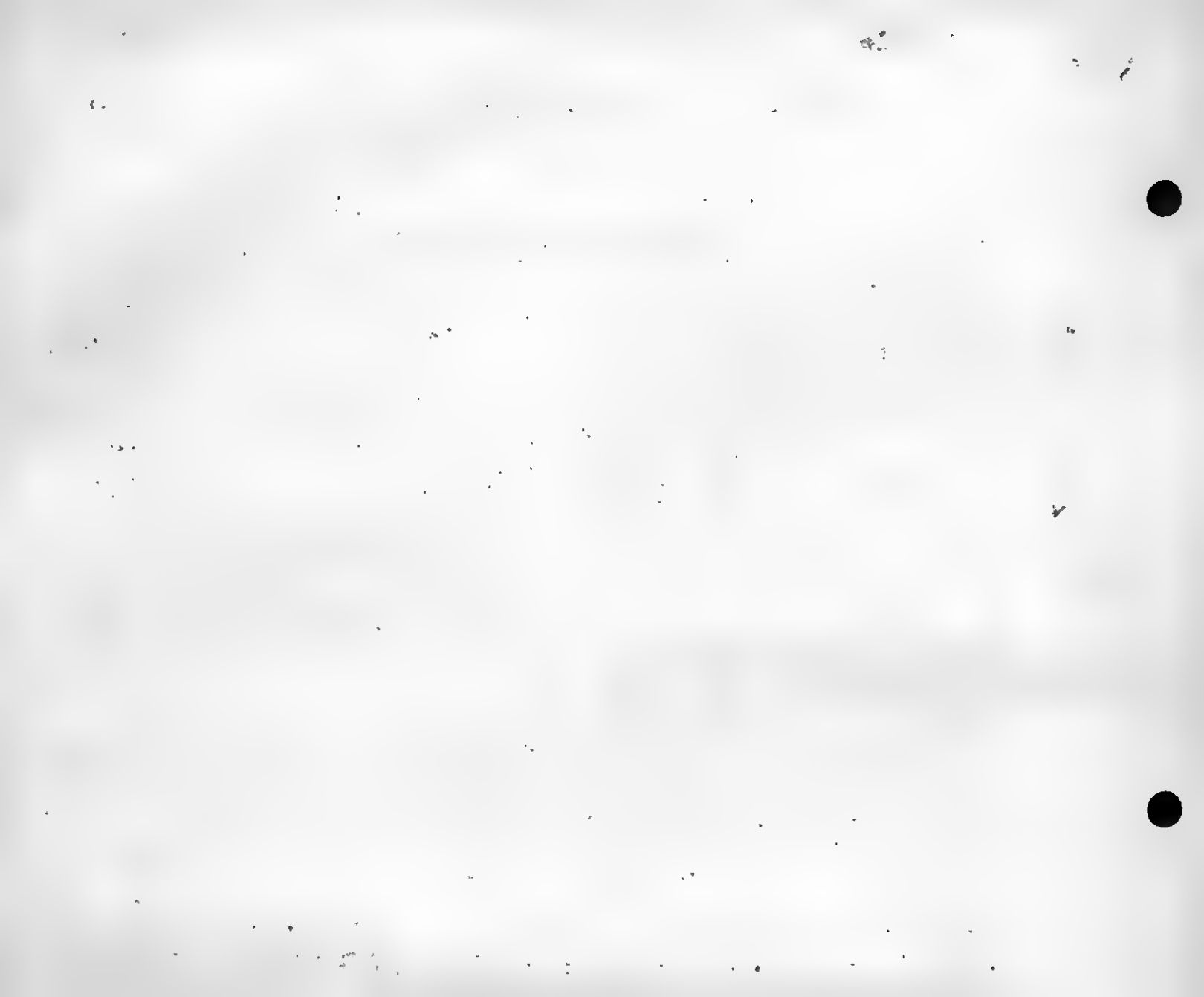
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CERTIFICATE OF DEATH

39404

39412

1. DECEASED-NAME (Type or print) FRANK C. LINHARDT			2a. DATE OF DEATH Month 7 Day 14 Year 68		2b. HOUR P M
3. SEX M	4. RACE W	5. DATE OF BIRTH 1-2-1904		6. AGE (In years last birthday) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ANNE ARUNDEL Md		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1027 BOUCHER AVE	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CIVIL SERVICE	12b. KIND OF BUSINESS OR INDUSTRY GOV.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.	13b. COUNTY A.A. Co	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1027 BOUCHER AVE	
14. FATHER'S NAME First FRANK Middle J. Last LINHARDT	15. MOTHER'S MAIDEN NAME First FRANCES Middle DOBIAL Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give year or dates of service)	17. INFORMANT CARRIE LINHARDT		Address # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Right Ventricular Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to 7-14 , 19 68 , that (I) (we) last saw the deceased alive on 7/13/68 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. Linhardt		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 7-14-68	
22d. PHYSICIAN'S NAME (Type) E. Linhardt		22e. ADDRESS Annapolis, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-14-68	23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.A. MD.	
24. FUNERAL DIRECTOR John M. Lydenoxenos		ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR JUL 17 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH	<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR
MACGARRET		Evans		Lynch	DEATH MATED	<input type="checkbox"/> 7	23	1968	P M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR
F	W	12/30/17	50 YRS			Month	7	Day 23	Year 1968
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH				
North Carolina		U.S.A.			Anne Arundel Co				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even retired)			12b KIND OF BUSINESS OR INDUSTRY
Annapolis			NOA-ANNE ARUNDEL GEN			Secretary			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER			
Maryland			Baltimore	Ruxton		1004 Rolandvue Ave.			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Garnett					Dunn	Margaret			Brown
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT				
No			244-18-9729		Mr. James M. Lynch Jr. 1004 Rolandvue Ave.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Electrocution</u>									<u>Instant</u>
7257 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOW AM P M 7-23 1968		Struck on wet floor - pushed up lamp.				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or RFD No		City or Town	County	State
		Home			Turkey point		ABCO	MD	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion on death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)			E. Linhardt			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-23-68	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
						ADDRESS (Street, city, town, or county)		AACO	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		7/26/68		Calvary Episcopal Church Cem.		Fletcher, N. Carolina			
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Wm. Cook-Brooks Towson 1050 York Rd. 21204						JUL 26 1968		Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
39406		CERTIFICATE OF DEATH						39414		
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Macey						July Month Day 1968		10:55A		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
Male		White		July 9 1968		YRS.		1 40		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		U.S.A.				Anne Arundel				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Glen Burnie		North Arundel Hospital		None						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland		Anne Arundel		Seyverna Park				276 Pertsch Rd.		
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
James Albert Macey						Carol Irene Dail				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		None		Mother						
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Amnion - Prematurity</u>								LIVED 1 HR. 40 MIN		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Abruptio Placenta</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.										
22b SIGNATURE		22c. DATE SIGNED								
<u>Paul J. Jinkens</u>										
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
		7-12-68		North Arundel Hospital		Glen Burnie, AA Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
Alfred Bryson, Jr. Administrator		AUL 18 1968		J. Charles Judge						

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Willie				M. Cleddon				Month 7 Day 2 Year 68		10:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Negro		3/18/80		88 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Unknown GA		U. S. A.				Anne Arundel Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Crownsville		Crownsville State Hospital		Unknown							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, LIM. 15?		13e. STREET AND NUMBER			
Maryland		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		607 Pennsylvania Ave			
4. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Dale				Bellord				Lillie		Rebison	
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
Unknown		257-14-6332		Hospital Records		Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic pneumonia											
7070 DUE TO, OR AS A CONSEQUENCE OF (b) Decubitus ulcers											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 715X DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
Left hip fracture, extravasation of blood, possible myocardial infarction or											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/11, 1968, to 7/2, 1968, that (I) (we) last saw the deceased alive on 7/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED	
Adolphus Hale		M.D.		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		7/2/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Adolphus Hale		1200 W North Ave									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		7/9/68		Mt. Calvary Cemetery		A A		County		Md	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Adolphus Hale		1200 W North Ave		JUL - 9 1968		Charles Judge					



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) ^{First} <u>MANAS</u> ^{Middle} <u>E.</u> ^{Last} <u>McGeady</u>						2a. DATE OF DEATH ^{Month} <u>7-</u> ^{Day} <u>30-</u> ^{Year} <u>68</u>			2b. HOUR <u>5:15 P.M.</u>		
3. SEX <u>M.</u>		4. RACE <u>W.</u>		5. DATE OF BIRTH <u>2-7-02</u>		6. AGE (In years last birthday) <u>66</u> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Ind</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>A.A. Co.</u> Md.					
10. CITY OR TOWN OF DEATH <u>SEVERNA PARK</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Old County Rd</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Ret. Pres.</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Home Const.</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Ind</u>			13b. COUNTY <u>A.A.</u>			13c. CITY OR TOWN <u>Severna Park</u>		13d. RESIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>Old County Rd</u>	
14. FATHER'S NAME ^{First} <u>John</u> ^{Middle} <u>McGeady</u> ^{Last} <u>Julia</u>				15. MOTHER'S MAIDEN NAME ^{First} <u>Julia</u> ^{Middle} <u>Cavanagh</u> ^{Last} <u>McGeady-Clove</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <u> </u>		17. INFORMANT <u>May Monica McGeady-Clove</u> Address <u> </u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.C.V.D. or atherosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Suicide</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>421</u>											
19a. DATE OF OPERATION <u>4-21</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u> </u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u> </u>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u> </u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u> </u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u> </u> , to <u>1968</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>7-30-68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert R. Hahn</u> MD DEGREE <u> </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>7-30-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>						22e. ADDRESS <u>P.O. Box 73 Severna Park</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE <u>8/1/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Severna Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Severna Park Ind</u>					
24. FUNERAL DIRECTOR <u>Robert R. Hahn</u>				ADDRESS <u>Severna Park</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 6 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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VR A15 (4)
304A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09409									
09417									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Elizabeth Middle Mitchell Last			2a. DATE OF DEATH 7 Month 14 Day 68 Year		2b. HOUR 12:45 AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 6-6-95		6 AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Ann Arundel Md			
10. CITY OR TOWN OF DEATH Glen Burnie		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before) Maryland		13b COUNTY A.A.Co.		13c CITY OR TOWN Severn		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Rt. 2 Box 109A	
14. FATHER'S NAME First John Middle Swanson Last			15. MOTHER'S MAIDEN NAME First Mary Middle Musch Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO —		17 INFORMANT Melvin Mitchell Rt. 2, Box 109A, Glen Burnie, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF <u>Intestinal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/12/68</u> , 19 <u>68</u> , to <u>7/13/68</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>7/13/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J.B. Ramirez MD</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>7/13/68</u>			
22d. PHYSICIAN'S NAME (Type)		<u>J.B. RAMIREZ MD</u>		22e. ADDRESS <u>3527 ANN ARUNDEL RD Galt 27</u> <u>324 Hospital Drive Glen Burnie</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-19-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie Anne Arundel, Md</u>			
24. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u>				ADDRESS <u>3021 Eastern Ave., Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 18 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09418												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) Norman			First E. Middle Montgomery Last			2a. DATE OF DEATH Month July Day 12 Year 1968			2b. HOUR 9:43AM			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 7-12-04			6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md						
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Trackman			12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. CITY OR TOWN Anne Arundel			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt. 2, Weiker Rd.				
14. FATHER'S NAME First Leonard Middle Montgomery Last			15. MOTHER'S MAIDEN NAME First Martha Middle ? Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO 717-07-6752			17. INFORMANT Address Norman E. Montgomery-Weiker Road Severn Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) Cerebro-Vascular accident												
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension												
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 8-5 , 1962, to 7-12 , 1968, that (I) (we) last saw the deceased alive on 7-12 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robert Dabolin MD DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) ROBERT DABOLIN, MD						22e. ADDRESS 400 CRAIN HWY NW GLEN BURNIE, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY Saints Rest Cemetery		23d. LOCATION (City or Town) (County) (State) Harmons, Maryland						
24. FUNERAL DIRECTOR Herbert E. Nutter-3015 W. North Ave.				ADDRESS		25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

CERTIFICATE OF DEATH

09412

09419

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
SAMUEL			E.	MORAN	7-19-68		9:30	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4-16-01		6. AGE (In years last birthday) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Construction		12b. KIND OF BUSINESS OR INDUSTRY Flooring		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 235
14. FATHER'S NAME First Middle Last John H. Moran		15. MOTHER'S MAIDEN NAME First Middle Last Bernice Hall						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO -		17. INFORMANT Mrs. Margaret Moran Elton				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 415								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4/21/1968, to 7/18/1968, that (I) (we) last saw the deceased alive on 7/18/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Edmond J. Tushabek				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/19/68		
22d. PHYSICIAN'S NAME (Type) EDMOND J. TUSHABEK				22e. ADDRESS North Arundel Hosp				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/22/68		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem		23d. LOCATION (City or Town) (County) (State) Glen Burnie Md		
24. FUNERAL DIRECTOR Robert S. Lawrence				ADDRESS same as above		25a. REC'D BY REGISTRAR DATE JUL 23 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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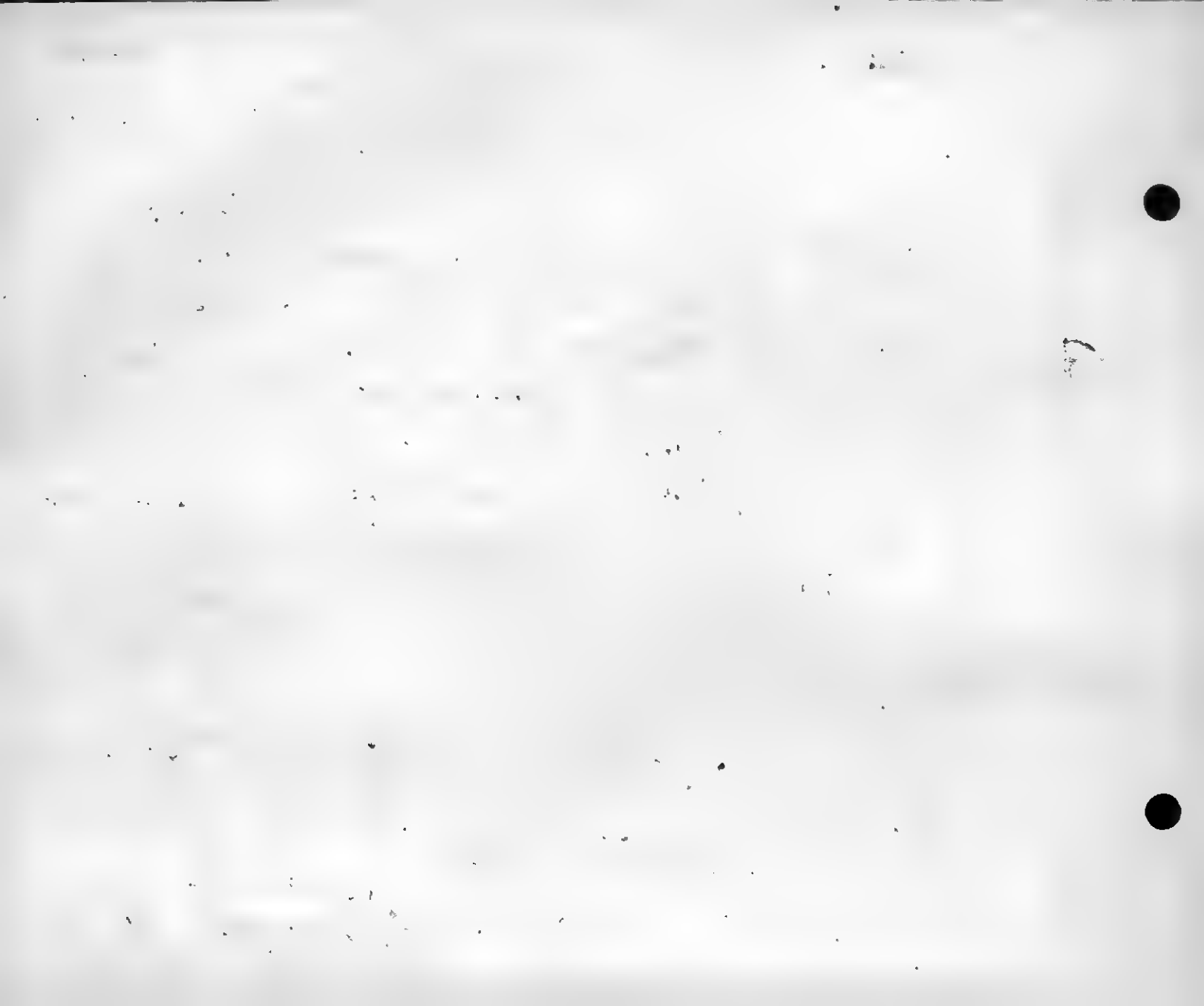
CERTIFICATE OF DEATH

00420

1. DECEASED-NAME (Type or print) Ethel		First	Middle	Last	2a. DATE OF DEATH Month 7 Day 15 Year 68			2b. HOUR 12 P M	
3. SEX F		4. RACE W		5. DATE OF BIRTH 4-30-1878		6. AGE (In years last birthday) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.			
10. CITY OR TOWN OF DEATH ANNE ARUNDEL		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ANNE ARUNDEL NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SCHOOL TEACHER		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN ANNE ARUNDEL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3 MURRAY AVE	
14. FATHER'S NAME William P. Baldwin		First	Middle	Last	15. MOTHER'S MAIDEN NAME AMANDA Stallings		First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT MARY E. Moss # 13		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1200 IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X mm									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1960 to 7-15, 1968 , that (I) (we) lost saw the deceased alive on 7-9-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frank McSherry M				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-15-68	
22d. PHYSICIAN'S NAME (Type) FRANK McSherry				22e. ADDRESS ANNE ARUNDEL					
23a. BURIAL, CREMATION, REMOVAL, ETC. BURIAL		23b. DATE 7-18-68		23c. NAME OF CEMETERY OR CREMATORY CEDAR BLVD		23d. LOCATION (City or Town) ANNE ARUNDEL		23e. COUNTY (State) A.A. MD.	
24. FUNERAL DIRECTOR John M. Lybrowsky				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The page remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

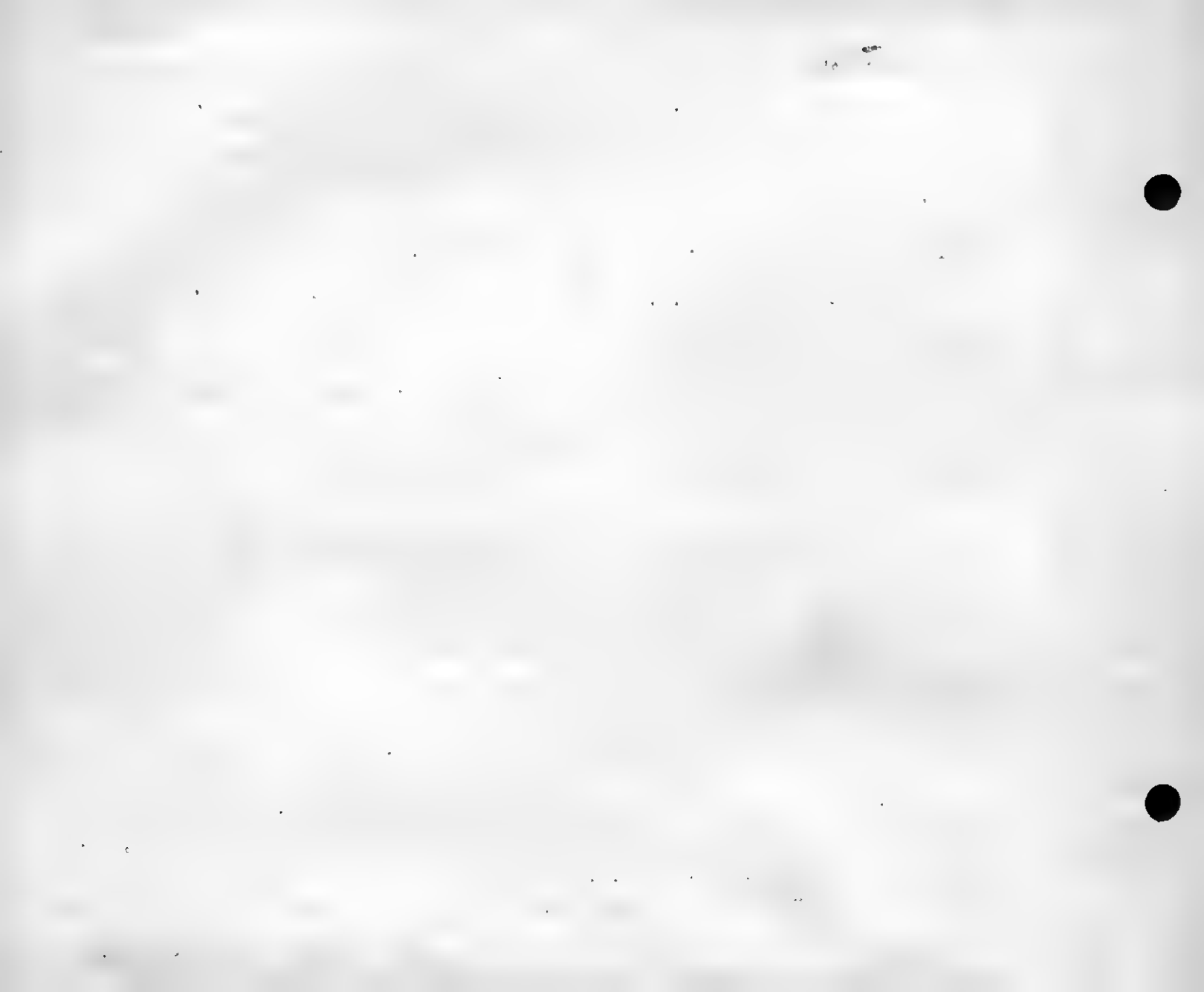
VR A15ME (5)
10M REV 1-7-68

Items 18&22a Film 402 Maryland State Department of Health
7-15-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

30421

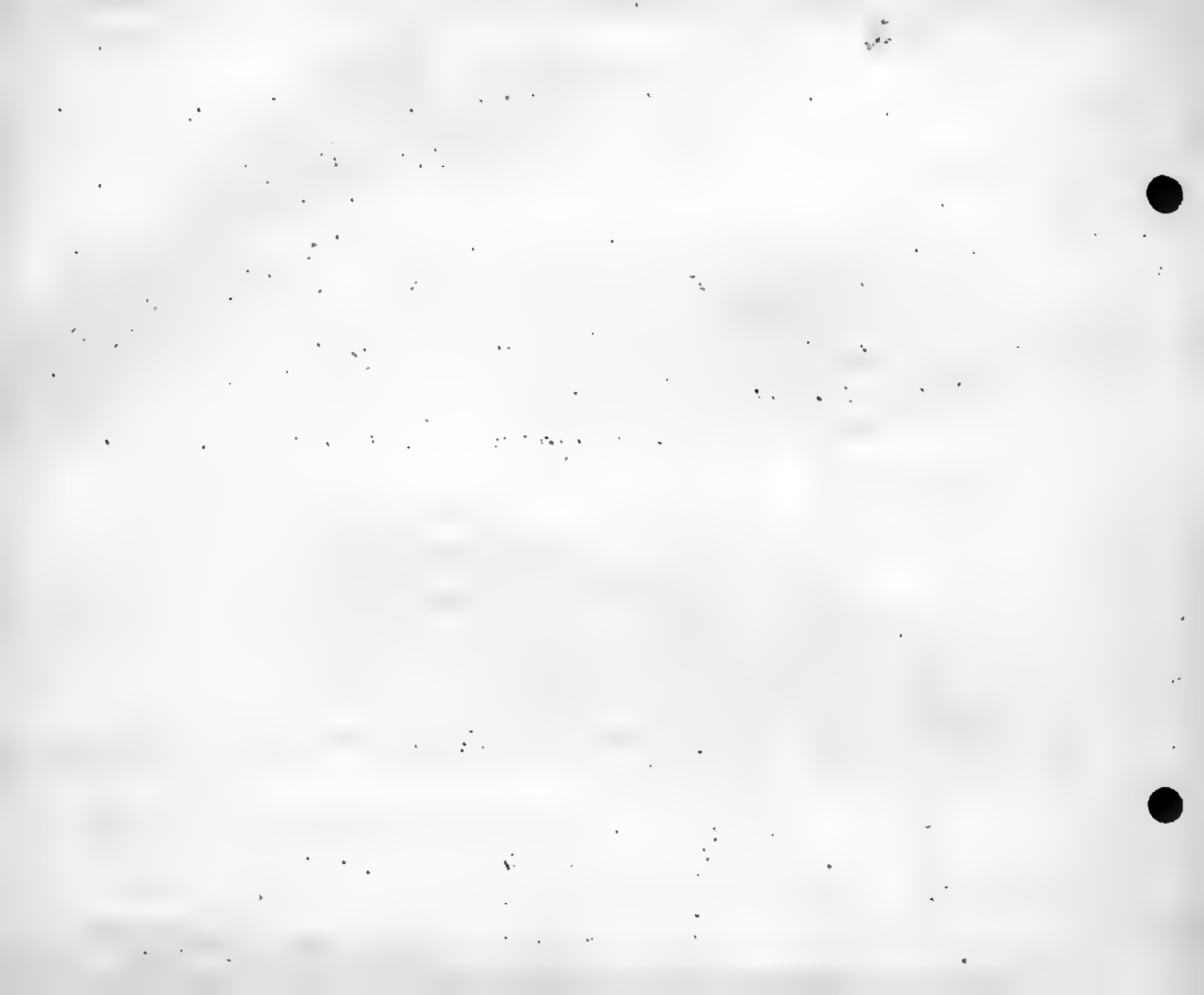
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
JOHN A. MULLEN III						7 4 1968			15:15						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. YRS	8. MONTHS	9. DAYS	10. HOURS	11. MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	Colored	3-1-67	15						Month Day Year			1968 5:15			
7a. BIRTH-PLACE (State or foreign country)			7b. CIT ZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
AA.Md			USA						Anne Arundel			Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Annapolis			Anne Arundel General Hosp.												
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
Md.			A.A.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Tracy's Landing			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
John H. Mullen			Shirley Bishop												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS						
						John H. Mullen			Tracy's Landing						
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Myocarditis															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
4200															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. PM 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				EDWARD F. WILSON M.D.				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				Edward F. Wilson, M.D.				July 5, 1968							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
				7-7-68				Bethel Way -Cross				Huntington Cal Md			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Linkney E. Sawell				Prince Fred. Mc				JUL 10 1968				Charles Judge			



Dr. Linhardt AA County Coroner
Notified & cleared
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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88414		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH 7/30/68 cac		19422			
1. DECEASED NAME (Type or print)		First Middle Last		Telephone call - Fun. Dir.		2a. DATE OF DEATH		2b. HOUR	
Elmer Dell Negley JR						Month Day Year July 18 1968		8:15 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR IF UNDER 24 HRS	
Male		White		13 MARCH 1921		47 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
KANSAS		USA				Ann Arundel Co.			
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
F. Geo G. Meade		Natl Security Agency		Analyst		US Gov't			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
VA Fairfax		ARLINGTON		Alexandria		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4121 Conrad Rd	
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
ELMER DELL NEGLEY JR				Julia Manning					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		Address			
Yes		1939-1959		224-52-5009		Med & Pers Records		N.S.A.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		5064		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100		Probable Massive Myocardial Infarct				1 HOUR			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		DUE TO, OR AS A CONSEQUENCE OF	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No. City or Town County State			
While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		None							
22a. I certify that (I) (this hospital) attended the deceased from		18 July, 1968, to		19		that (I) (we) last saw the deceased alive on		18 July 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Warren G. Preisser MD								18 July 1968	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
WARREN G. PREISSER MD		NSA Med Ctr, F. Geo G. Meade							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
7/22/68				ARLINGTON NATIONAL C		ARLINGTON			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. SIGNATURE					
Robert R. Vull		JUL 23 1968		Robert R. Vull					



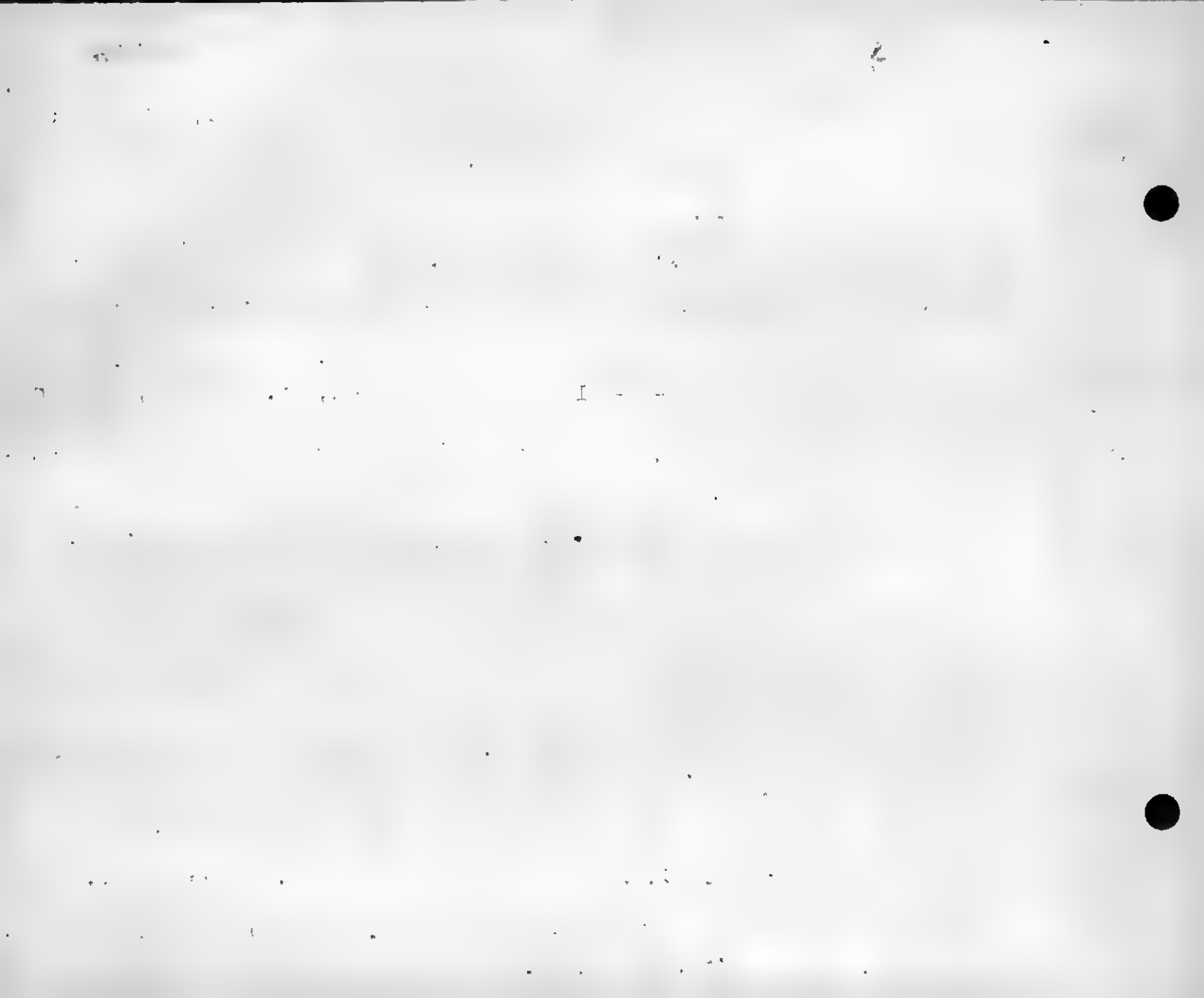
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Sarah Jane NEIGHOFF					July 17 1968		4:00 P.		
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS M. N.		
Female	White		Jan. 29, 1899		69 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	U.S.				Anne Arundel Md.				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel General Hosp.		Home Maker		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		611 Riverside Drive,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Lewis Fefal			Mary Gallagher						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address					
no		215-22-2016		William Neighoff, Jr. Pasadena, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive mesenteric thrombosis								2 days	
1341 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) huge ventral hernia (partly resected)								6 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) Peritonitis (resected)								15 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 7/16, 1968, to 7/17, 1968, that (I) (we) lost the deceased alive on 7/17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type) Samuel Borssuck, M.D.									
22e. ADDRESS									
Amos Garrett Blvd., Annapolis, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
23b. DATE									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION (City or Town) (County) (State)									
Burial 7/20/1968 Glen Haven Memorial Pk. Glen Burnie, Maryland									
24 FUNERAL DIRECTOR									
Robert P. Ware									
25a. REC'D BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE									
DATE JUL 24 1968									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A
Evelyn			Harris	PARKER		July 19 1968			6:30 M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		August 23, 1914		53 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Tennessee		U.S.				Anne Arundel Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel Gen. Hosp.		CLERK		INS.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1995 Fairfax Road
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
			UNK			UNK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
No					Joseph H. Parker # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized (primary colon)</u> 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1538 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 29, 1962, to July 19, 1968, that (I) (we) last saw the deceased alive on July 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Charles W. Kinzer					DEGREE ATTENDING PHYS.		MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 19, 1968
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.					22e. ADDRESS 16 Murray Ave, Annapolis Md. 21401				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		7-22-68		Hillcrest		ANNAPOILIS H.A. MD.			
24. FUNERAL DIRECTOR John M. Layton					ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR JUL 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
30M REV 1-68

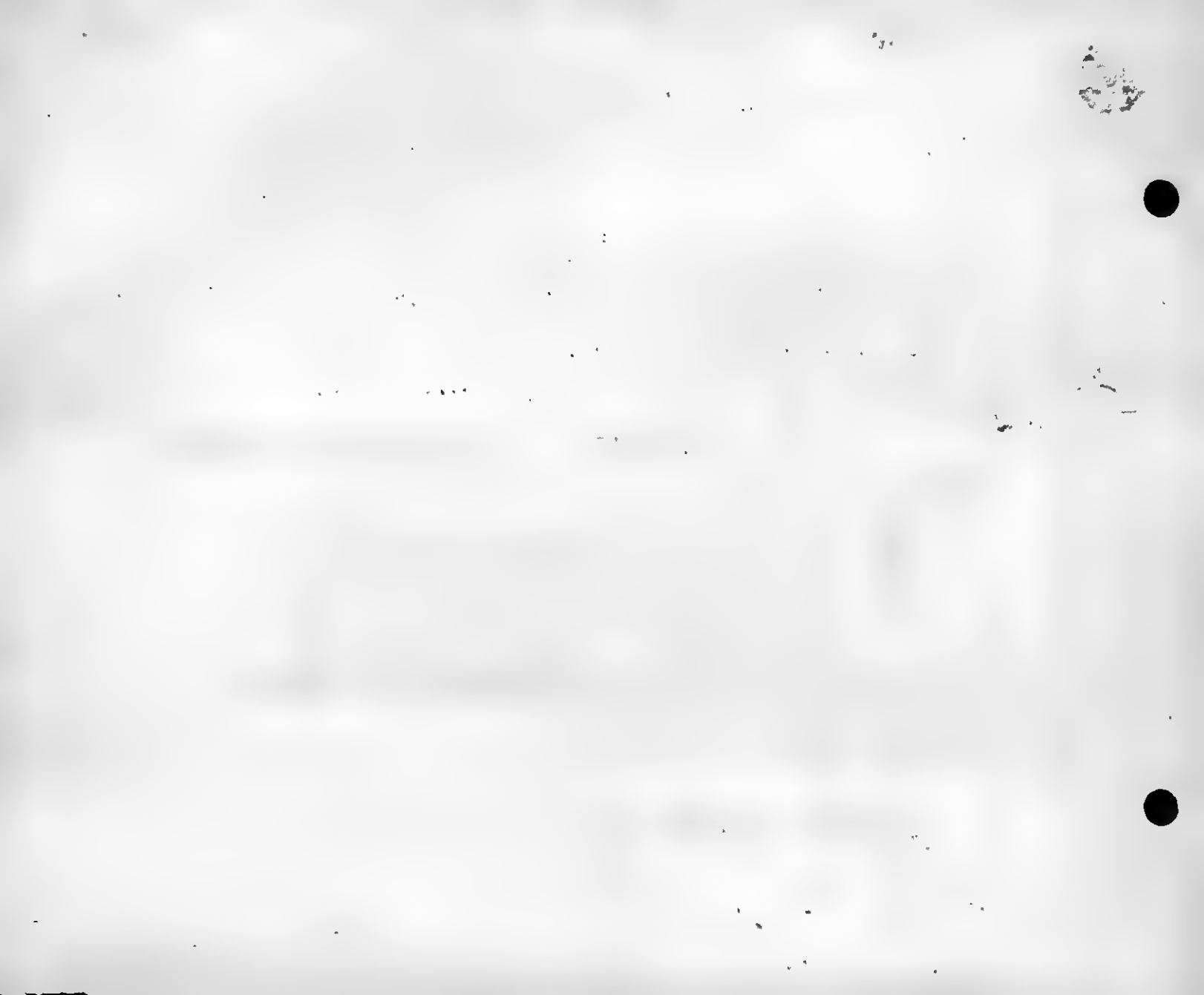
39417

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

63425

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) BERNARD Charles PARKINSON			2a. DATE OF DEATH July Month 13 Day 1968 Year			2b. HOUR 4:35 P.M.	
3. SEX Male		4. RACE white		5. DATE OF BIRTH May 13 1967		6. AGE (In years last birthday) 1 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH A A Co	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) A. A General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) —		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY AA Co		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1135 Madison St		14. FATHER'S NAME First Middle Last BERNARD Wesley PARKINSON JR		15. MOTHER'S MAIDEN NAME First Middle Last SHERRY DENISE HARDESTY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. —		17. INFORMANT B.W. Parkinson		Address ANNAPOLIS Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION OF ASPIRIN IN LUNG 915X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 923.7							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) ASPIRATED ASPIRIN			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jonathan M. Miller M.D.				DEGREE MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS AA Co Md	
24. FUNERAL DIRECTOR Harcdesty Funeral Home, ANNAPOLIS, Md				25a. REC'D BY REGISTRAR DATE JUL 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the state department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10426	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First <i>L. H.</i> Middle <i>B.</i> Last <i>Pitts</i>			2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b HOUR		
3 SEX <i>F</i>			4 RACE <i>N</i>		5 DATE OF BIRTH <i>MAY 1930</i>		6 AGE (In years last birthday) <i>38</i> YRS		2c DATE PRONOUNCED DEAD Month <i>7</i> Day <i>3</i> Year <i>1968</i>		
7a BIRTHPLACE (State or foreign country) <i>Georgia</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>A. Aco.</i>		
10 CITY OR TOWN OF DEATH <i>ANNAPOLIS</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>DOA - Home Amdel. gen</i>			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>New Jersey</i>			13b. COUNTY <i>Cumberland</i>			13c CITY OR TOWN <i>Bridgeton</i>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>MARK</i> Middle <i>Andrew</i> Last <i>MARTHA</i>			15. MOTHER'S MAIDEN NAME First <i>MARTHA</i> Middle <i>CUNKNOWN</i> Last <i>CUNKNOWN</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SEC. ID NO <i>UNKNOWN</i>		
17 INFORMANT <i>CHARLES A Pitts</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>multiple infarcts</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>817.9</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>last</i>			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year <i>7-3 1968</i>		
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Auto accident Route 50</i>			21d PLACE OF INJURY (At home, farm, street, factory, office building, etc) <i>Highway</i>			21e LOCATION Street or R F D No <i>Route 50</i>			21f City or Town <i>ACW</i> County <i>MD</i> State <i>MD</i>		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			23a. BURIAL CREMATION, (Specify)			23b. DATE <i>July 9, 1968</i>		
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>			23d. LOCATION (City or Town) <i>Hopewell Twp.</i> (County) <i>Cumberland</i> (State) <i>New Jersey</i>			24. FUNERAL DIRECTOR <i>Charles F. Bell Jr.</i> ADDRESS <i>Hopping Funeral Home</i>			25a. REC'D BY REGISTRAR <i>JUL - 8 1968</i>		
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			25c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>			25d. DATE SIGNED <i>7-3-68</i>			25e. ADDRESS (Street, city, town or county) <i>AAAC</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

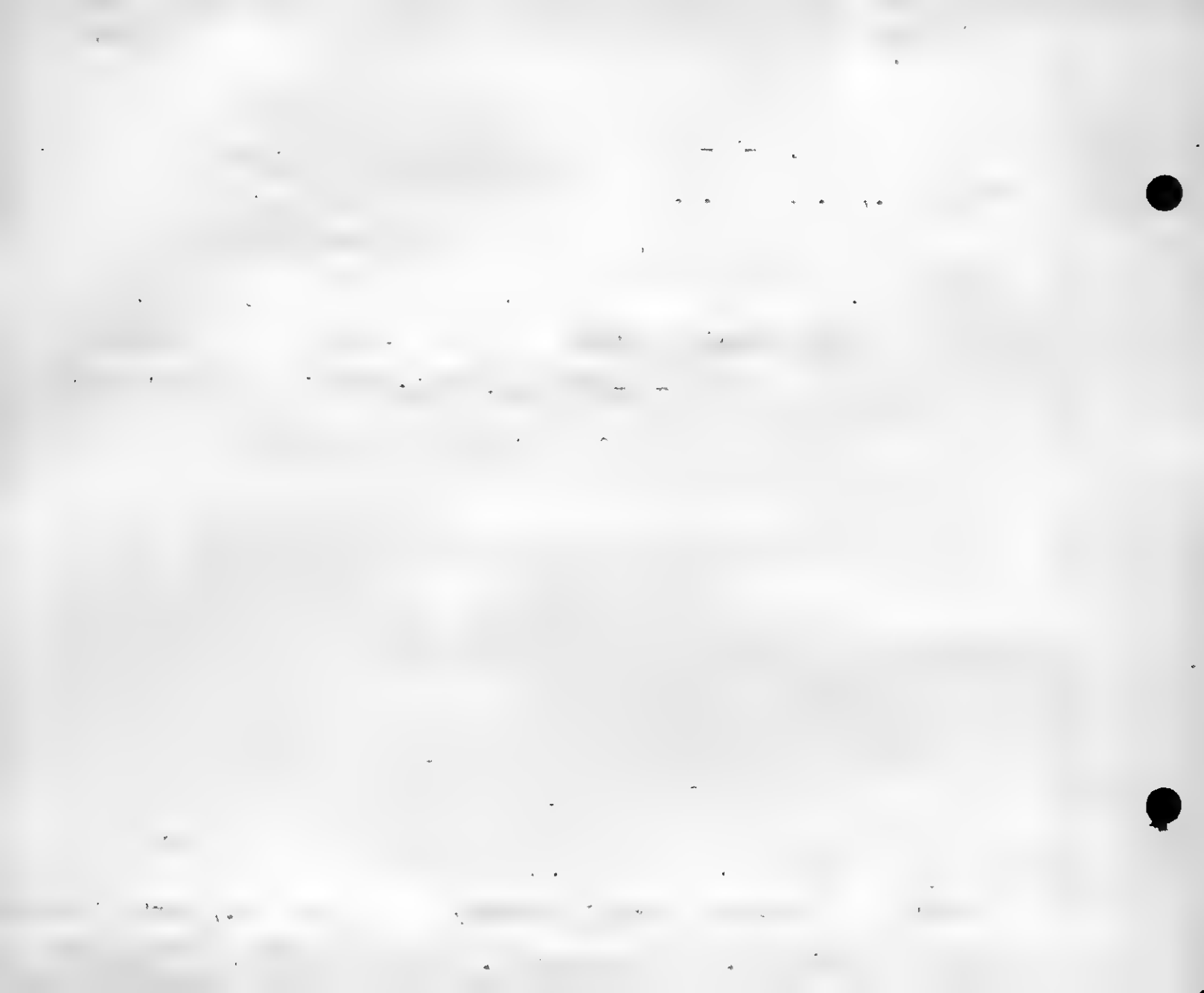
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print) Amelia G Podgurska					2a. DATE OF DEATH Month 2 Day 68 Year 7				
3 SEX Female		4 RACE White		5. DATE OF BIRTH 6-26-92		6. AGE (In years lost birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Ed.		13b. COUNTY Baltimore		13c. CITY OR TOWN Balt		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3122 Foster Ave.	
14. FATHER'S NAME First Middle Last Michael Kulinski					15. MOTHER'S MAIDEN NAME First Middle Last Anna Zgiarski				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17 INFORMANT 213 S. Ellwood Ave. Elsie A. Romanowski: Balto., 21224, Md.					
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Route Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF ASHT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASHT DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6/30/68 to 7/2/68 , that (I) (we) last saw the deceased alive on 7/2/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J.B. Ramirez		DEGREE J.B. RAMIREZ		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/2/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 3921 ANNAPOLIS RD Balt 27 Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-6-68		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City or Town) (County) (State) 7301 German Hill Rd., Md.			
24. FUNERAL DIRECTOR Charles J. Jailer		901 S. Conkling St. Balto., 21224, Md.		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE Charles Jailer			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 10-100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
CLARENCE			POWELL			Month Day Year		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
Male	Colored	5-10-30	38 YRS	MONTHS DAYS	HOURS MIN.	Month Day Year		2:50p	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Rocky Mt., N.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Anne Arundel		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Annapolis		Anne Arundel		Cement Finisher					
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE			13b. COUNTY			13c. STREET AND NUMBER			
Md.			Balto.			1103 Myrtle Ave.			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Alex Powell			India Clanton						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		
			243-40-2845		Mrs. Elsie Powell		1103 Myrtle Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH		HOUR A.M. P.M.		19					
22a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)			Charles S. Springgate, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 11, 1968	
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		7-14-68		Powell Cemetery		Nash Co., North Carolina			
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MORTON & DYETT F.H. 1701 Laurens St.						JUL 12 1968		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT GEORGE G MEADE				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KILBROUGH ARMY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last REESE JR.				4. DATE OF DEATH Month JULY Day 2 Year 19 68			
5 SEX MALE	6. COLOR OR RACE CAU.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 JULY 1968	9. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 10 Min. 12	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN BABY			10b. KIND OF BUSINESS OR INDUSTRY NEWBORN		11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME JOHN WESLEY REESE				14. MOTHER'S MAIDEN NAME ALICE SUSAN SHRECK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. N.A.		17. INFORMANT JOHN W. REESE, 517 AMBERLY RD., GLEN BURNIE		Address IE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) APNEIC EPISODE 7769 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) PREMATURITY DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						INTERVAL BETWEEN ONSET AND DEATH 30 minutes LIFE	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N.A.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. N.A. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N.A.		20f. (City or town) (County) (State) N.A.	
21. I certify that (I) (this hospital) attended the deceased from 7:30AM 2 July 68 to death 2 July 68 that (I) (we) last saw the deceased alive on 2 July 19 68 , and that death occurred at 11:22 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Fred M. Nomura</i>				22b. DATE SIGNED 2 July 1968		22c. PHYSICIAN'S NAME (Type) FRED M. NOMURA, MAJ, MC	
22d. ADDRESS KILBROUGH ARMY HOSP, FT G. G. MEADE				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk		23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR <i>E. R. Thomas</i> SINGLETON FUNERAL HOME				25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

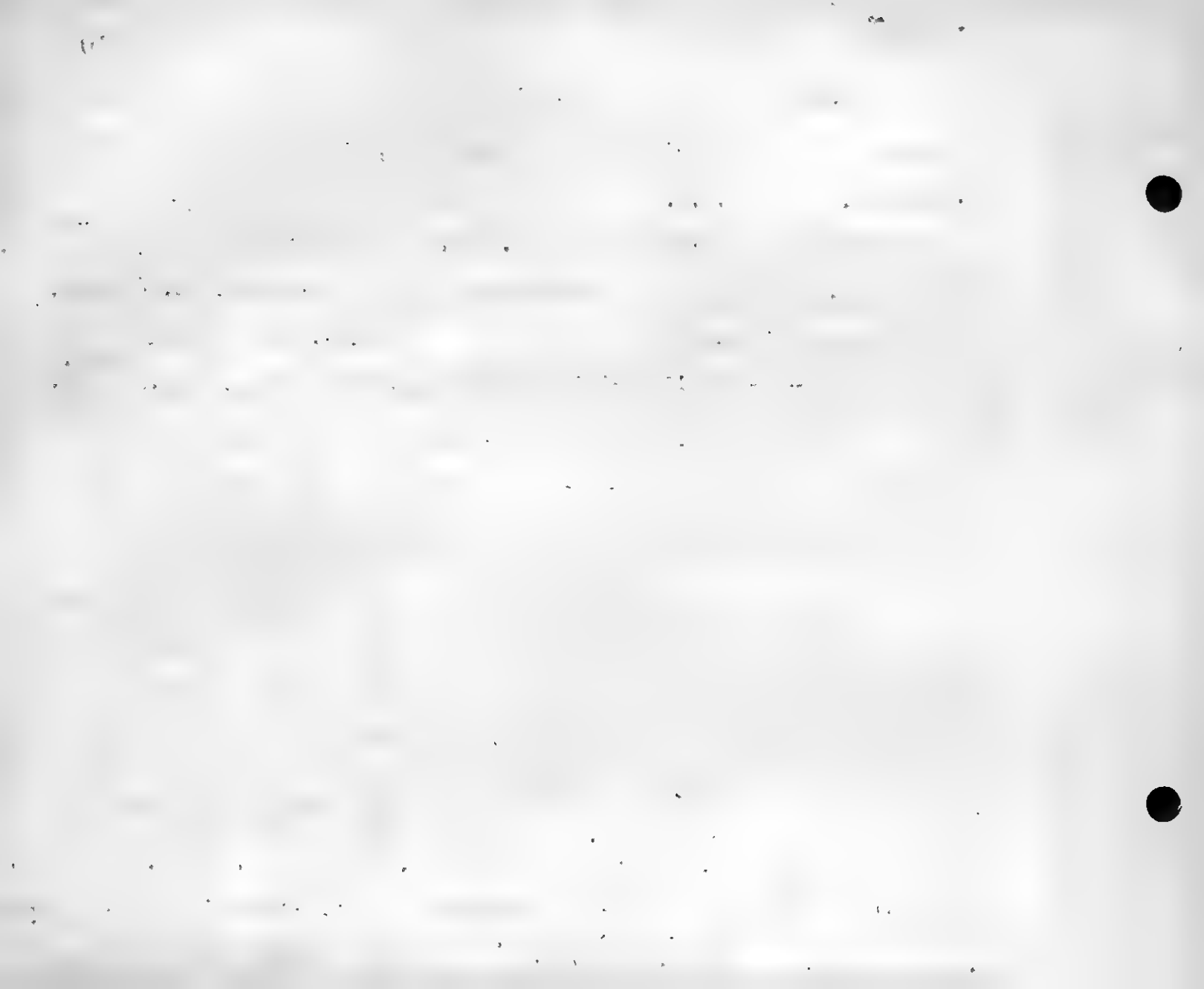
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) JOHN			First Middle Last RETTMAN			2a. DATE OF DEATH Month July Day 13 Year 1968		2b. HOUR 7:00P.	
3. SEX Male		4 RACE White		5 DATE OF BIRTH January 29, 1902		6 AGE (In years last birthday) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel		Md	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Gen. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist		12b KIND OF BUSINESS OR INDUSTRY Cork & Seal Co.		Md	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 351 Bonsal St. # 21224.	
14 FATHER'S NAME First Middle Last John Rettman			15. MOTHER'S MAIDEN NAME First Middle Last Katherine Koumet						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) No (If yes give war or dates of service)			16b SOCIAL SECURITY NO 213-01-6723		17 INFORMANT Barbara Rettman		Address 351 Bonsal St., Balto., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>7 years</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 19, 1966</u> , to <u>7-11, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Jason H. Gaskel</i>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7-15-68		
22d PHYSICIAN'S NAME (Type) JASON H. GASKEL					22e ADDRESS 637 S. Conkling St., Balto., 21224, Md.				
23a. BURIAL, CREMATION, REMOVAL, ETC. Burial		23b. DATE 7-16-68		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City or Town) (County) (State) 7401 German Hill Rd., Balto., Md.			
24. FUNERAL DIRECTOR <i>Charles S. Zeiler</i>		24a ADDRESS 901 S. Conkling St. Balto., 21224, Md.		25a REC'D BY REGISTRAR JUL 18 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

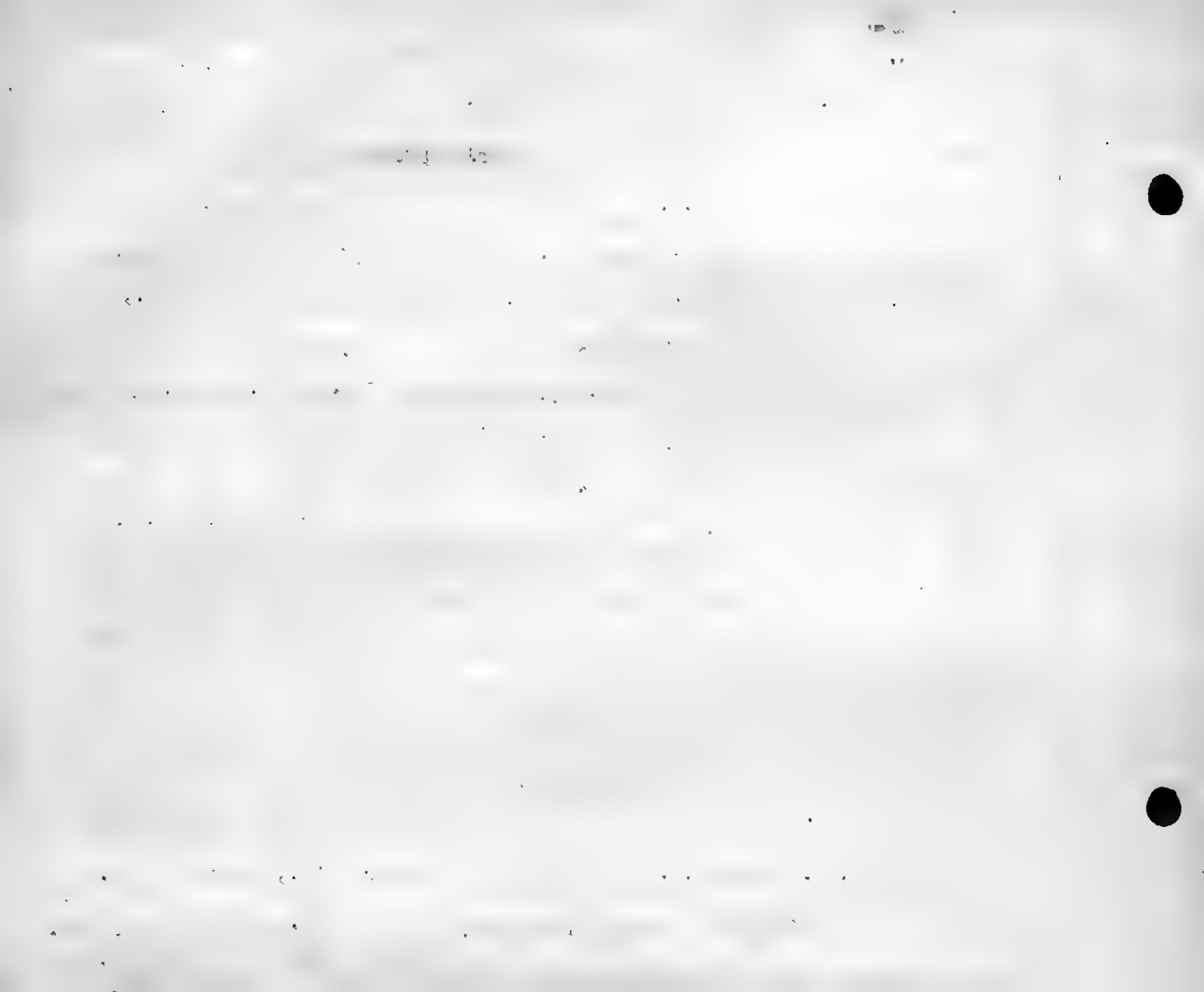
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR P.		
Mabel			RICHARDSON			July 9 1968		3:49 P.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Female		Negro		April 12, 1896		72 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.				Anne Arundel		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis		Anne Arundel Gen. Hospital		Maid		Hospital				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Anne Arundel		Annapolis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		35 Cathedral St.,	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
John			Richardson			Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
			215-24-3296A		Georgia Boston 1940 West St., Anna.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral Hemorrhage</u> (c) <u>Hypertension</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>A. T. Allen</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/10/68				
22d. PHYSICIAN'S NAME (Type) A. T. Allen, M.D.				22e. ADDRESS 62 Cathedral St., Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7/13/68		Pine Lawn Mem. Pk		Annapolis AA Md.				
24. FUNERAL DIRECTOR Wm. Reese, 108 W. Washington St., Anna.				25a. RECD BY REGISTRAR JUL 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00432

1 DECEASED NAME (Type or Print) JAMES		First		Middle		Last		2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> July 28, 1968		2b HOUR 9:35 PM	
3 SEX Male		4 RACE Negro		5. DATE OF BIRTH		6 AGE (In years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Anne Arundel		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Route 3			
14. FATHER'S NAME John		First		Middle		Last		15 MOTHER'S MAIDEN NAME Edith Queen		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (If not give year or dates of service) 216-16-4128		17. INFORMANT		ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Traumatic Injuries 8/20 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 9:00 PM July 28, 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver in auto-auto collision			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street				21f. LOCATION Street or R.F.D. No City or Town County State MD. Rte. 3 Gambriels Anne Arundel M.D.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion ACTUAL SIGNATURE Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. EXAMINER'S NAME (Type) ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED July 29, 1968 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8/2/68		23c. NAME OF CEMETERY OR CREMATORY Wilson Memorial		23d. LOCATION (City or Town) (County) (State) Gambriels A. Arundel					
24. FUNERAL DIRECTOR William Geese, II - Anna, Md.				ADDRESS				25a. REC'D BY REGISTRAR JUL 30 1968		25b. John Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										3438			
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR	
Joseph W Riley									Month Day Year July 12 1968			7:25 AM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		July 12 1923				44 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Anne Arundel Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Glen Burnie			North Arundel Hospital			Cement Worker							
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Ohio			Miami			Tippecanoe City		YES <input type="checkbox"/> NO <input type="checkbox"/>		9997 South State Rt. 202			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
John E. Riley									Bertha A. Blackburn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address							
no			414 24 9822			Mrs. Goldie M. Riley (wife) Same As #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a))													
4129 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
(b) Asbestosis Heart Disease													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
4.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from 7-9, 1968, to 7-11, 1968, that (I) (we) lost saw the deceased alive on 7-10-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED										
Alejandro Montoya			7-11-68										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
ALEJANDRO MONTOYA			1707 OLD ANNAPOLIS Rd. Q.P.										
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			July 15, 1968		Meadowridge Memorial Park.			Elkridge, RFD, Md.					
24. FUNERAL DIRECTOR			25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Singleton Funeral Home			DATE JUL 12 1968			J. Charles Judge							
Glen Burnie, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

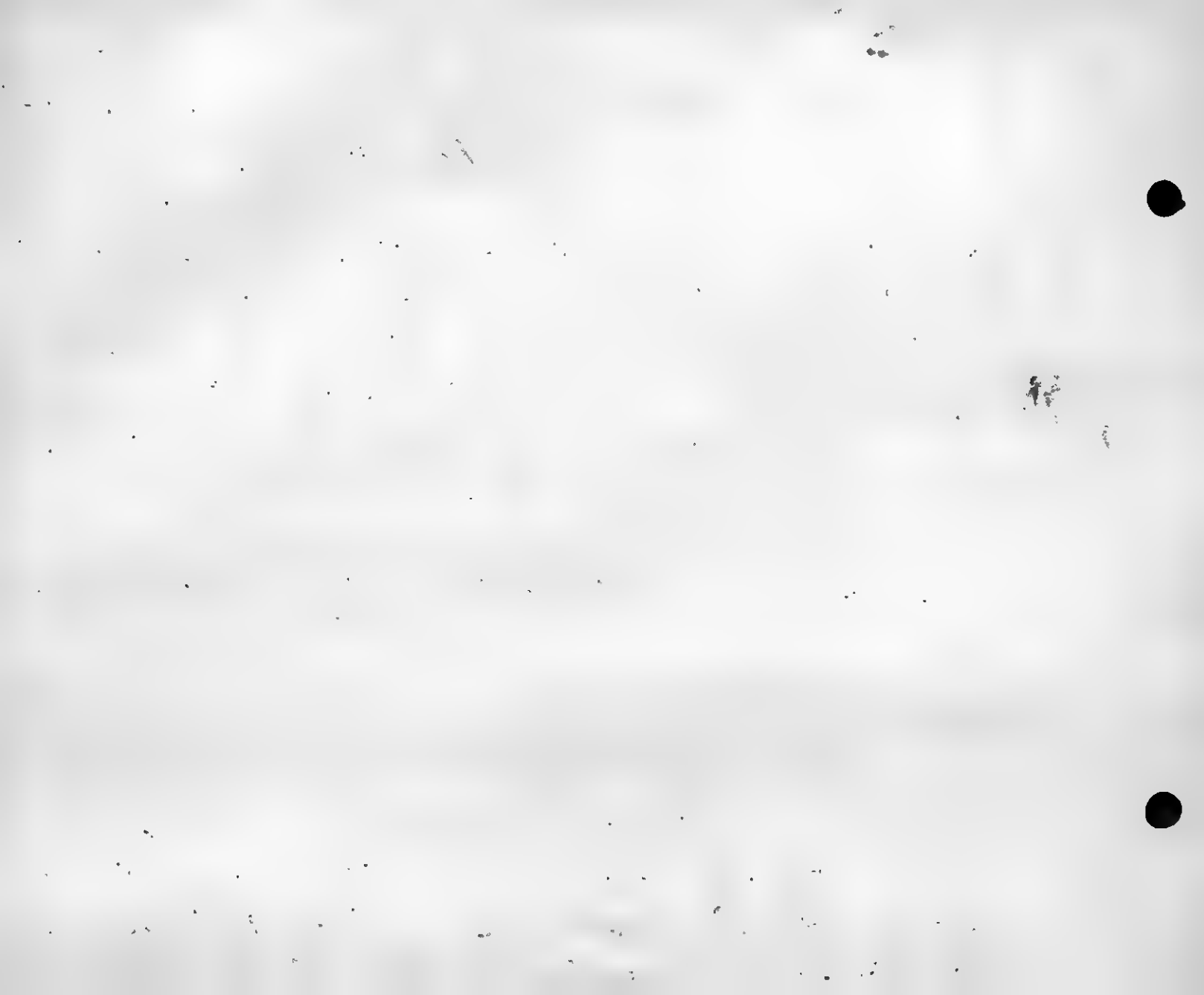
1 DECEASED-NAME (Type or print) First Middle Last HILARY CECIL ROWE			2a. DATE OF DEATH Month Day Year JULY 12 68			2b. HOUR 2330 M					
3 SEX MALE		4 RACE CAUCASION		5. DATE OF BIRTH 15 AUGUST 1909		6 AGE (In years last birthday) 58 YRS.		7 UNDER 1 YEAR MONTHS DAYS 10 27		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) ANNAPOLIS, MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.					
10. CITY OR TOWN OF DEATH ANNAPOLIS, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVHOSP, ANNAPOLIS, MD.		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RIVERVIEW AVE, WEEMS CREEK			
14. FATHER'S NAME First Middle Last ROSCOE CONKLING ROWE			15. MOTHER'S MAIDEN NAME First Middle Last REGINA CATHERINE DAMMEYER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 33 YR thru 60			16b. SOCIAL SECURITY NO. 176-32-0723		17. INFORMANT Address ANNAPOLIS, MD. MRS. DORALE ROWE, RIVERVIEW AVE, WEEMS CREEK						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLIZATION 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 41											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 2240 12 JUL 19 68 , to 2330 12 JUL 68 , that (I) (we) last saw the deceased alive on 2330 12 JUL 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE BARRY J. COUGHLIN		DEGREE LCDR MC USN		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 14 JULY 1968 21402					
22d. PHYSICIAN'S NAME (Type) BARRY J. COUGHLIN		22e. ADDRESS STAFF, NAVAL HOSPITAL, ANNAPOLIS, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-17-68		23c. NAME OF CEMETERY OR CREMATORY U.S.N. ACADEMY		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.D. MD.					
24. FUNERAL DIRECTOR W. H. Taylor		ADDRESS John P. Taylor		25a. REC'D BY REGISTRAR DATE JUL 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH		2b HOUR		
Claude Meredith RUSSELL						July Month 26, Day 1968.		3:25 M		
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS		
M		W		8-12-1890		77 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
MD.		U.S.A.				Anne Arundel County, Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Annapolis			A.A. GENERAL Hospt			Civil Service		Postal Dept.		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD.			A.A.			Annapolis		1110 MADISON ST.		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last	
Charles H. Russell						Elba Dawes				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
YES			WWI			Loretta Russell #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS								3 DAYS		
DUE TO, OR AS A CONSEQUENCE OF										
(b) ARTERIO SCLEROSIS								15 YEARS		
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
PARKINSON'S DISEASE DIABETES MELLITUS CARCINOMA PROSTATE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M.								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from April, 1967, to 26 July, 1968, that (I) (we) last saw the deceased alive on 22 July 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Edward S. Beck									7/26/68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Edward S. Beck, M. D.					73 Franklin St., Annapolis, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		7-29-68		MEADOWRIDGE		ELKIDGE HOWARD MD.				
24. FUNERAL DIRECTOR					25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John M. Sproules Annapolis, Md.					JUL 30 1968		Charles Jones			



CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) CLARA A. SCHMIDT		2. DATE AND HOUR OF DEATH 7/7/68 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Anne Arundel County 214 Hill Top Road		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 214 HILL TOP ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/1913
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 55
13. FATHER'S NAME CHARLES SCHMIDT		11. BIRTHPLACE (State or foreign country) PENNA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		12. CITIZEN OF WHAT COUNTRY U.S.A.	
16. SOCIAL SECURITY NO.		17. INFORMANT Thomas Schmidt 214 Hill Top Rd. Baltimore	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of stomach - intestinal 6 months ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 151x OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (GIVEN IN PART 18A) 22. I certify that (I) (this hospital) attended the deceased from 4/1/68 to July 7, 1968 and that (I) (we) last saw the deceased alive on July 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Sidney R. Gehlert		23B. DATE SIGNED 7/8/68	
23C. PHYSICIAN'S NAME (Type) Sidney R. Gehlert		23D. ADDRESS 4700 Pennington Ave. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/11/68	24C. NAME OF CEMETERY or CREMATORY Fountain Springs Cemetery	24D. LOCATION (City, town, or county) (State) ASHLAND, PENNA.
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1968		25B. NAME OF REGISTRAR Charles Judge	
25C. FUNERAL DIRECTOR Kell Funeral Home Ashland Pa.		ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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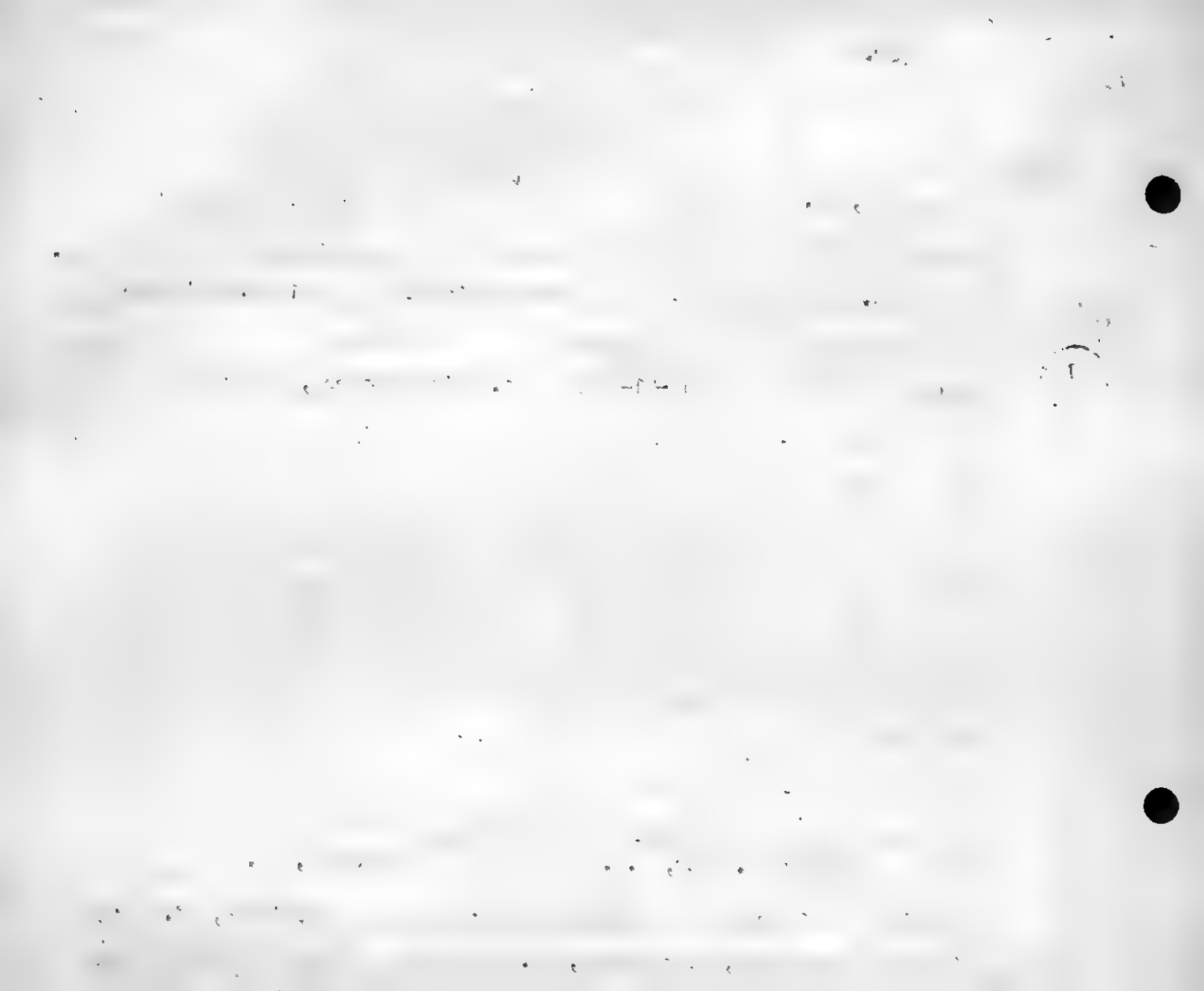
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

69437

1. DECEASED-NAME (Type or print) Bernard Harman Schoberg			2a. DATE OF DEATH Month 7 Day 20 Year 68			2b. HOUR 1:15 A M	
3. SEX M		4. RACE W		5. DATE OF BIRTH 3-21-1909		6. AGE (In years last birthday) 59 YRS.	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Annapolis Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ANNAPOLIS NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Postal Clerk		12b. KIND OF BUSINESS OR INDUSTRY Ret.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 1012 Stewart Lane		14. FATHER'S NAME First HERMAN Middle SCHOBERG Last SCHOBERG		15. MOTHER'S MAIDEN NAME First Rose Middle Gaudner Last Gaudner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. WW 2 216-01-9855		17. INFORMANT Mrs. Alice Schoberg, same as 13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331x (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROSIS, GENERALIZED, PREVIOUS CVA.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 20 OCT 1965 , to 20 JULY 1968 , that (I) (we) last saw the deceased alive on 16 JULY 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward S. Beck				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/20/68	
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, D.				22e. ADDRESS Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 23 July 68		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md. 21225	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.				25a. REC'D BY REGISTRAR DWUL 22 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
00430 CERTIFICATE OF DEATH 09438													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
RICHARD			BERNARD		SCHORR				Month Day Year July 14 1968		M		
3. SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
male			cauc.			May 25, 1910			58 YRS				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			USA						Anne Arundel Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY				
Glen Burnie			North Arundel			grocer			retail				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Anne Arundel			Severn			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 2 Box 23		
14 FATHER'S NAME			First			Middle			15 MOTHER'S MAIDEN NAME			First Middle Last	
Lawrence H. Schorr									Margaret			Foye	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
yes			II			213-09-0140			Gertrude C. Schorr - same as #13 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>4104</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>421</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 24</u> , 19 <u>67</u> , to <u>July 14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Morton M. Krieger</u>			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED				
			Morton M. Krieger, M.D.			615 Hammonds Lane Balto. Md. 21225			July 15, 1968				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			July 17, 1968			Baltimore Nat'l Cemetery			Baltimore Maryland				
24. FUNERAL DIRECTOR <u>Everley E. Hopping</u>			ADDRESS <u>Baltimore</u>			25a. RECD BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
HOPPING FUNERAL HOME - Annapolis, Md.						JUL 17 1968							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
I'm 586, Film 403 7/31/68 km											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) Arthur Sherrill SCOTT						2a. DATE OF DEATH Month July Day 20 Year 1968			2b. HOUR 6:55 M		
3 SEX Male		4. RACE Negro		5. DATE OF BIRTH Aug 18/20 1917		6 AGE (In years last birthday) 51 YRS		7E UNDER 1 YEAR MONTHS		7F UNDER 24 HRS. DAYS	
7a BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTRY OF DEATH Anne Arundel			Mc		
10 CITY OR TOWN OF DEATH Crownsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hosp				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tailor			12b KIND OF BUSINESS OR INDUSTRY Garment		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 1808 N. Broadway			
14. FATHER'S NAME First Shadrack Middle Scott Last Scott				15 MOTHER'S MAIDEN NAME First Isabella Middle Wright Last Wright							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16b SOCIAL SECURITY NO. 1945-1946 219-07-8459		17. INFORMANT Medical Records - Crownsville Hospital				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia. DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration and Inanition DUE TO, OR AS A CONSEQUENCE OF (c) Acute and Chronic Alcoholism.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 6 Wks Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June 14th 1968 to July 20th 1968 , that (I) (we) last saw the deceased alive on July 20th 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lionel M. Henry Mapp		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED July 20th 1968	
22d. PHYSICIAN'S NAME (Type) Lionel M. Henry Mapp		22e. ADDRESS Crownsville State Hospital, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7.25.68		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave.				ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the ward "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First <i>William</i>			Middle <i>HENRY</i>			Last <i>SELLERS</i>		
2a DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year			2b HOUR <i>A M</i>			2c DATE PRONOUNCED DEAD Month <i>7</i> Day <i>22</i> Year <i>1968</i>		
3 SEX <i>M</i>			4 RACE <i>W</i>			5 DATE OF BIRTH <i>3-10-08</i>			6 AGE (In years last birthday) <i>60</i> YRS		
7a BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			7b CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Anne Arundel Co</i>		
10 CITY OR TOWN OF DEATH <i>Glen Burnie</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>St. A-North. Arundel-Hosp</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>			13b COUNTY <i>Baltimore</i>			13c CITY OR TOWN <i>Baltimore</i>			13d STATE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14 FATHER'S NAME <i>George W. Sellers</i>			15 MOTHER'S MAIDEN NAME <i>Sarah L. Stephens</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO. <i>217-01-8807</i>		
17 INFORMANT <i>Iola V. Everly</i>			ADDRESS <i>4761 Chaple Sq. Arbutus Md.</i>			18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Carcinoma Lung</i> <i>Radical Mastectomy</i> DUE TO, OR AS A CONSEQUENCE OF <i>Radical Mastectomy</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Gradual</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>16.3 x</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		
21c. LOCATION Street or R.F.D. No			City or Town			County			State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>E. Linhardt</i>			EXAMINER'S NAME (Type) <i>E. Linhardt</i>			M.D.			22b. DATE SIGNED <i>7-22-68</i> <i>A.A. Co.</i>		
23a. BURL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>7-25-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Frederick Ave., Balto. Md.</i>		
24. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>			ADDRESS <i>4107 Wilkens Ave. Balto 29</i>			25a. REC'D BY REGISTRAR DATE <i>JUL 24 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
Eva						SELLMAN		Month July Day 11 Year 1968			9:40 M
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		7. YRS.	
Female		Colored		5-1-1903				65			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
Md.		U.S.A.		WIDOWED		DIVORCED		Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis		General Housewife									
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Anne Arundel		Annapolis		YES		15. Habel Ave.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S M maiden name		First Middle Last	
Fred		Bias		Phillie		Smothers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
		217348493		Eliza Powell		11 Habel Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4519										1 day	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
165X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES		NO			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year									
(If either, notify medical examiner)		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/>											
at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS		MED. DIRECTOR		STAFF PHYS		22c. DATE SIGNED	
Wm T. Allen				M.D.						7-13-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS							
Wm T. Allen		1111 Adams		1111 Adams							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		7-17-68		Adams		Tolman		Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William Reese		1111 Adams		JUL 16 1968		John Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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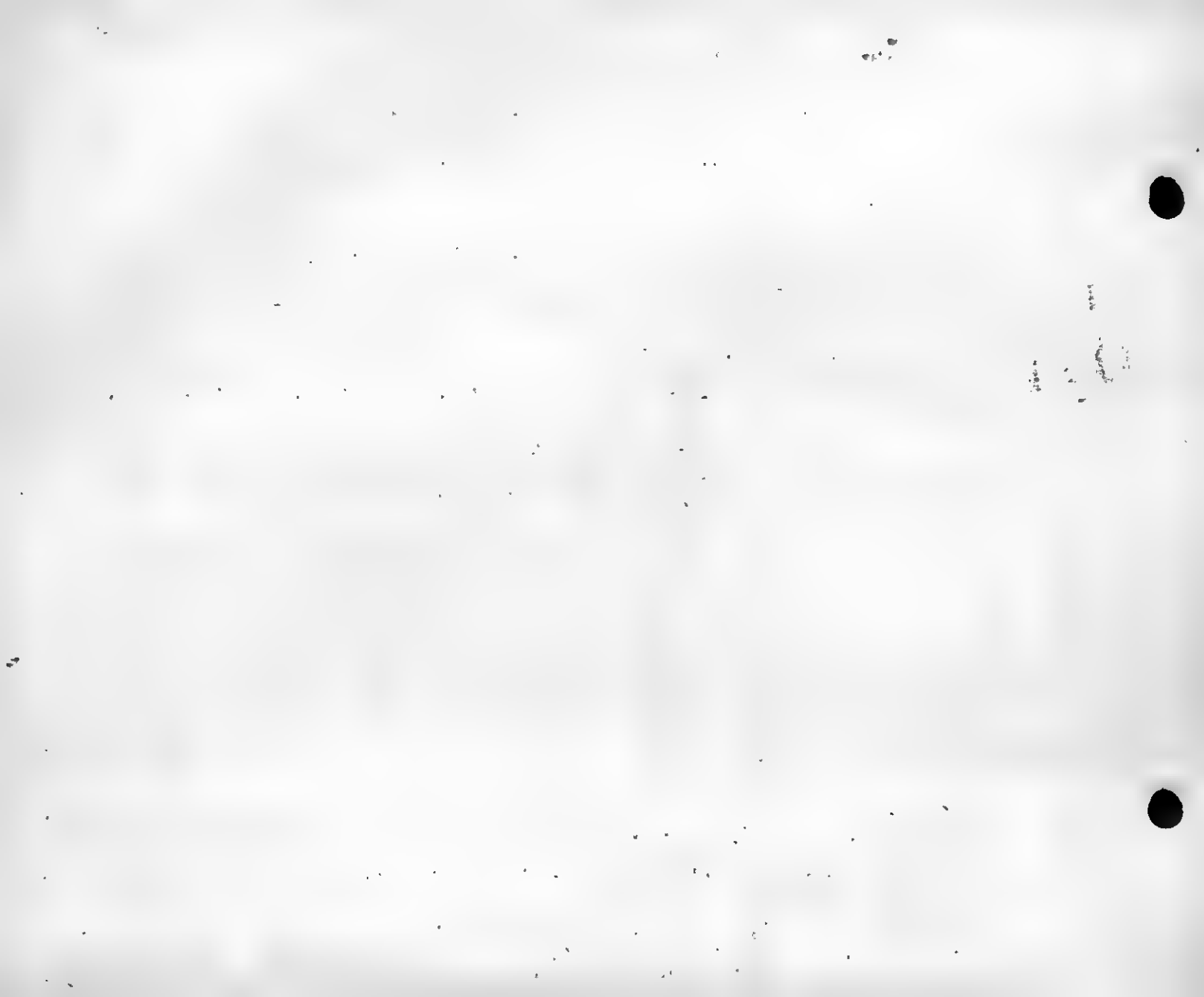
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

20134

CERTIFICATE OF DEATH

3442

1. DECEASED-NAME (Type or print) First Middle Last Thomas Clifford Seltzer, Sr.			2a. DATE OF DEATH Month Day Year July 29 1968			2b. HOUR M	
3 SEX male		4. RACE cauc.		5. DATE OF BIRTH Sept. 13, 1908		6. AGE (In years last birthday) 59 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Anna Arundel General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) carpenter		12b. KIND OF BUSINESS OR INDUSTRY Boat building	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Lodland Beach		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last Francis M. Seltzer		15. MOTHER'S MAIDEN NAME First Middle Last Ethel Forman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 215-07-7446		17. INFORMANT Address Thomas C. Seltzer, Jr. Edgewater, Md.			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate Unknown							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420.1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> hat while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/31, 1962 to 7/29, 1968, that (I) (we) last saw the deceased alive on 5/31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard I. Hochman, M.D.				DEGREE ATTENDING PHYS.		22c. DATE SIGNED 7/30/68	
22d. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.				22e. ADDRESS 16 Murray Ave. Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 1, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Washington Md.	
24. FUNERAL DIRECTOR E. Hopping Hopping Funeral Home - Annapolis, Md.				25a. REC'D BY REGISTRAR DATE JUL 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>Josephine (Johanna) Seubott</i>			2a. DATE OF DEATH Month <i>7</i> Day <i>1</i> Year <i>68</i>			2b. HOUR <i>8 P. M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov. 25, 1884</i>		6. AGE (In years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.			
10. CITY OR TOWN OF DEATH <i>Baltimore 26. Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>none</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Orford Bay</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1000 Belvidere Place</i>	
14. FATHER'S NAME First <i>Patrick</i> Middle <i>Doyle</i> Last <i>Doyle</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Roche</i> Last <i>Roche</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO <i>2</i>		17. INFORMANT <i>Mrs Henry Young</i>		Address <i>same</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cardiac decompensation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i> <i>2 years</i> <i>2 years</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>501X</i> <i>none</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>June 10, 1968</i> to <i>July 1, 1968</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>June 30, 1968</i> and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (<i>we</i>) (<i>did</i>) (<i>did not</i>) view the body after death									
22b. SIGNATURE <i>R.M. McLaughlin</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/1/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>					22e. ADDRESS <i>3708 Mountain Rd. Pasadena, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>7/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Catholic Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>4300 Old Frederick Rd. Md.</i>			
24. FUNERAL DIRECTOR <i>John F. Cowanston Inc.</i>					ADDRESS <i>901 Hollins St.</i>		25a. REC'D BY REGISTRAR <i>JUL - 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expedited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain in the hospital papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <i>Albert</i>			2a DATE OF DEATH <i>July 28 1968</i>			2b HOUR <i>12:45</i> M					
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>8/11/03</i>			6. AGE (In years last birthday) <i>64</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>A.A. County</i> Md.		
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>North Arundel Con. Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>operator- telephone pub. utility</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>			13c. CITY OR TOWN <i>Annapolis</i>			13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>Alfred R.</i> Middle <i>Wilance</i> Last <i>Delashment</i>			15. MOTHER'S MAIDEN NAME First <i>Namie</i> Middle <i>Delashment</i> Last <i>Id.</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go to (1) (If yes give war or dates of service) <i>NO</i>				16b. SOCIAL SECURITY NO <i>212-03-68564</i>	
17. INFORMANT <i>Albert R. Lewis - 18 N. Linden Ave. Annapolis</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Left ventricular failure</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple myeloma</i>			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cachexia</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>203X Aneurysm</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/26, 1968</i> to <i>7/28, 1968</i> , that (I) (we) last saw the deceased alive on <i>7/28, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Max C Frank</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>7/28/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>MAX C FRANK MD</i>			22e. ADDRESS <i>425 E. Pike Hwy - Glen Burnie</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>July 31, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Cooksville Howard Md.</i>		
24. FUNERAL DIRECTOR <i>L. Hopping</i>			ADDRESS <i>Hopping Funeral Home - Annapolis, Md.</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
DATE <i>JUL 31 1968</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

19445

1. DECEASED NAME (Type or print) EDWARD			First Middle Last M. SKALSTAD			2a. DATE OF DEATH Month JULY Day 23 Year 1968			2b. HOUR 11:30								
3 SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 10-21-06			6. AGE (In years lost birthday) 61 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) CALIFORNIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ANNE ARUND L								
10. CITY OR TOWN OF DEATH GREEN BELT			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NORTH ARUNDEL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ENTILER			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.			13b. COUNTRY OF RESIDENCE USA			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2256 PARK HEIGHTS AVE.					
14. FATHER'S NAME First Unk Middle Last			15. MOTHER'S MAIDEN NAME First Unk Middle Last														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO 213-10-6974			17. INFORMANT Family			Address Same								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial 410.7 DUE TO, OR AS A CONSEQUENCE OF Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 7-20 , 19 68 , to 2-27 , 19 68 , that (I) (we) last saw the deceased alive on 2-24-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Robert Dabolins MD DEGREE MD ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. PHYS. PHYS.												22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) ROBERT DABOLINS, MD			22e. ADDRESS 400 Crain Hwy N.W. Glen Burnie Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7/27/68			23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem			23d. LOCATION (City or Town) (County) (State) Ritchie Hwy AA Co Md								
24. FUNERAL DIRECTOR McCully F.H. 737 Patapsco Ave			25a. REC'D BY REGISTRAR JUL 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
MARVIN		T		SLATER				Month <input checked="" type="checkbox"/> 7 Day 14 Year 68		A M	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR
M	W	2-5-08		60 YRS	MONTHS DAYS		HOURS MIN		Month 7 Day 14 Year 68		A M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		U.S.A.				P.A.CO.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Glen Burnie		D.D.A. North ARUNDEL		Self-Emp. (ret.)		Ice Business					
13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
MD		ANCO				YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt 3-Box 20 - Severn - Md.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
Cory Slater				Estelle Leopold							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
No				217-07-9491		Mrs. Betty A. Luzier (daughter) Severn, Md.					
18 CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u>											
4399 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4344											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. P.M. 19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
<u>E. Lubarsch</u>		E. Lubarsch						<input checked="" type="checkbox"/>		7-14-68	
				ADDRESS (Street, city, town, or county)						P.A.CO.	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		July 17, 1968		Nichols Bethel Cemetery		Odenton, Maryland					
24. FUNERAL DIRECTOR		SINGLETON FUNERAL HOME		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
<u>R. V. Singleton</u>		GLEN BURNIE, MARYLAND		DATE JUL 17 1968		<u>Charles Judge</u>					

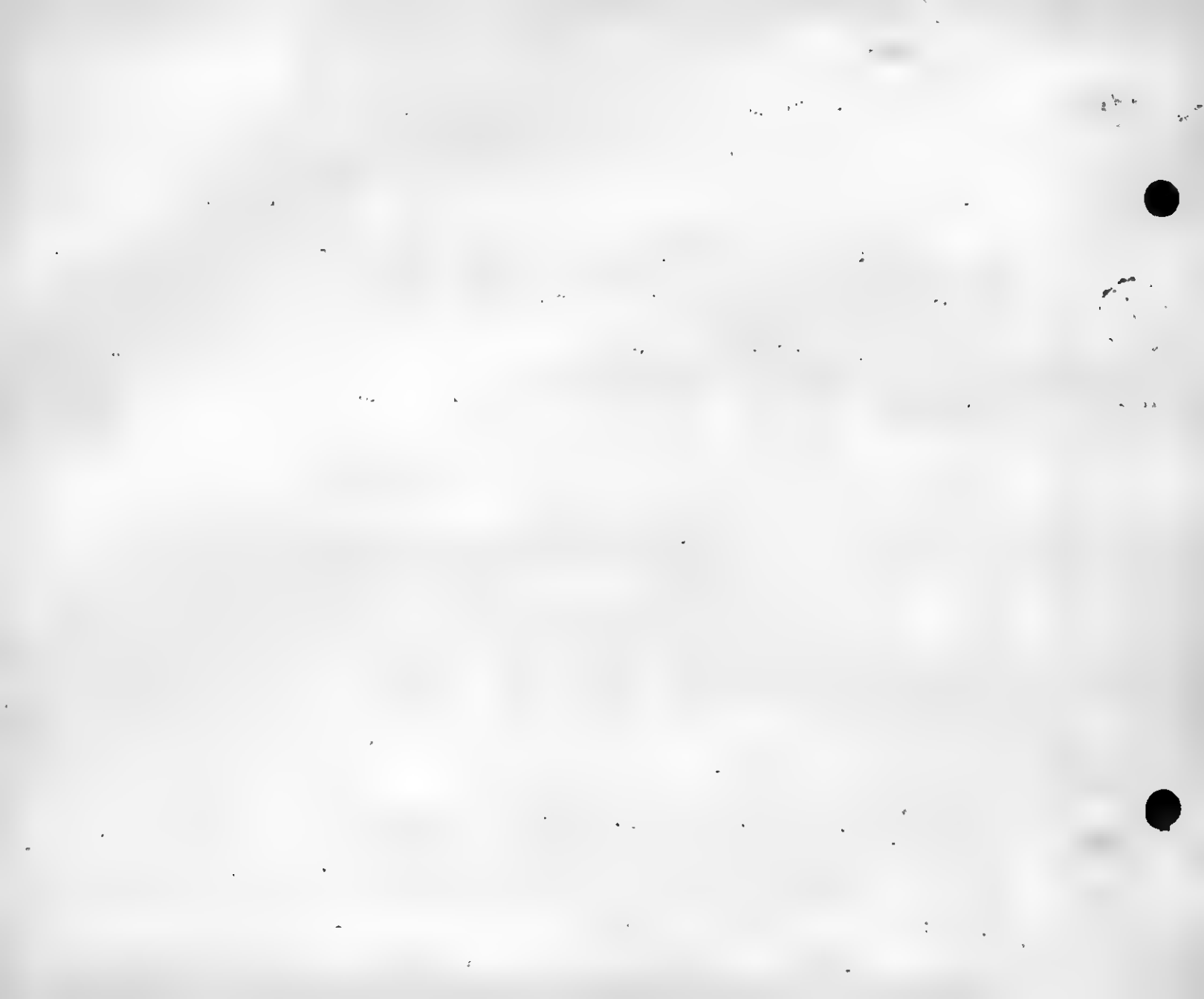


CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Winfield Scott Smith Third					7 17 68		11:30 AM	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		2/26/20		48 YRS.			
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania	U.S.A.				Anne Arundel Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Crownsville		Crownsville State Hosp.		Artist				
13a US-AL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Maryland		Anne Arundel		Annapolis				Hillsmere 627 Harbor Dr. p Shores
14. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
Winfield Scott Smith Jr.					Pearl Van Dwyne			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address		
unknown				264-64-0694		Hospital Records, Crownsville Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Pneumonia								
3032 DUE TO, OR AS A CONSEQUENCE OF								
(b) Hepatic failure								
DUE TO, OR AS A CONSEQUENCE OF								
(c) Chronic alcoholism								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6/27, 1968, to 7/17, 1968, that (I) (we) last saw the deceased alive on 7/17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
Charles R. Venter, M.D.		7/18/68		Charles R. Venter, M.D.		Crownsville State Hospital, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Cremation		7/19/68		Fort Lincoln		Washington D. C.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Charles F. Bell Jr.		JUL 22 1968		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



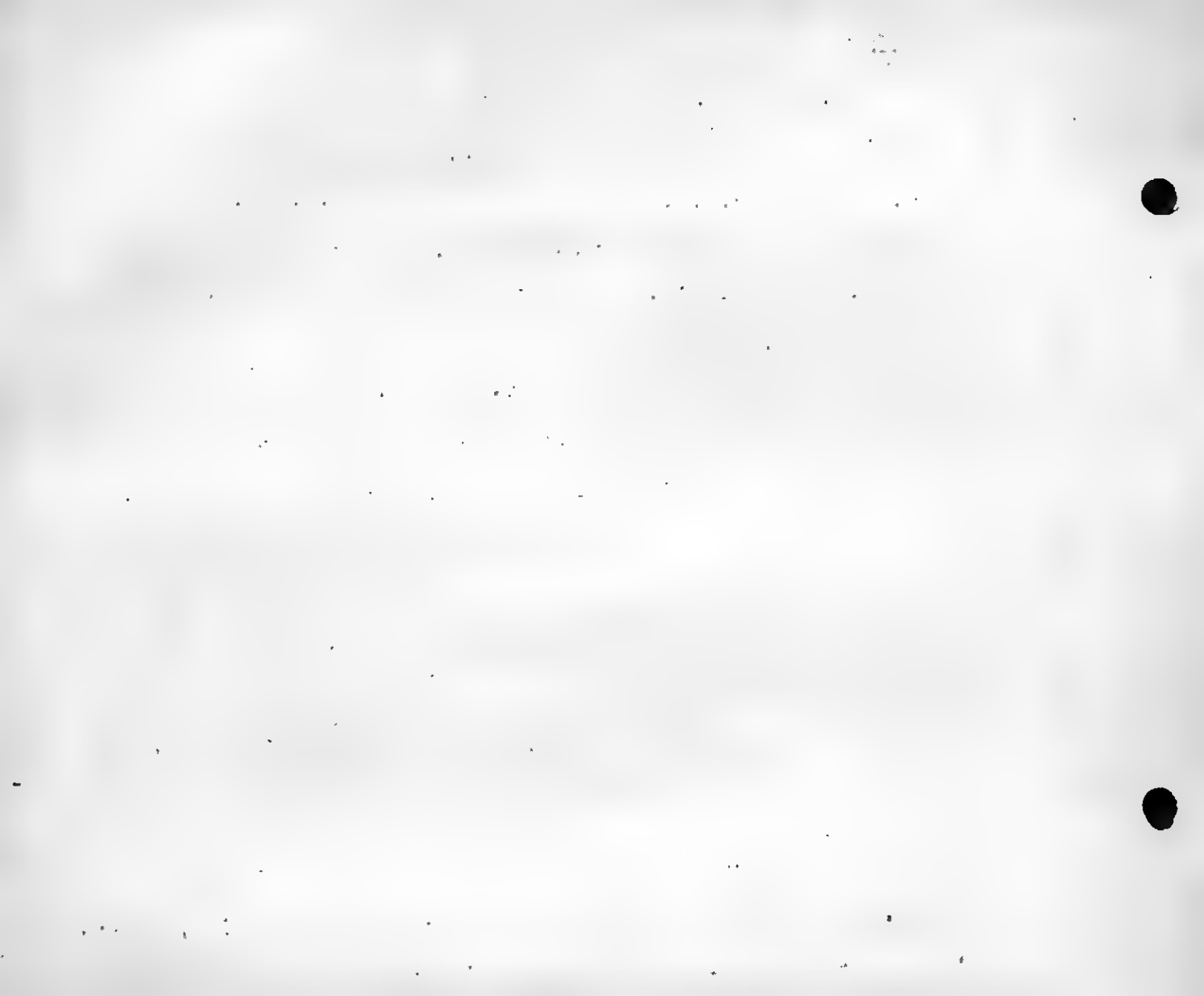
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Asenath E.				Smoot	Month 7 Day 3 Year 68		8 P. M.	
3. SEX	Female		4. RACE	White		5. DATE OF BIRTH		6. AGE (in years lost birthday)
						Oct. 30, 1880		87 YRS
7a. BIRTHPLACE (State or foreign country)	Md.		7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH
								A.A. Co. Md.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Glen Burnie		North Arundel Hosp.		Homemaker				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.		Balto. ✓		Baltimore				501 Castle Drive
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Samuel D. Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
				Rev. John M. Smoot		406 Stevenson L. a		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>								HRS
DUE TO, OR AS A CONSEQUENCE OF								
(b) <u>Arteriosclerotic Cardiovascular Dis.</u>								YRS
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No. City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>								
22a. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1965</u> , to <u>July 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>MOR - 24 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
<u>W. J. Venable, Jr.</u>		7-5-68		J. J. VENABLE, JR		7215 YORK RD - BALTIMORE MD		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		7/8/1968		Druid Ridge Cemetery		Pikesville, Balto. Md		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Mitchell Wiedefeld Home		JUL - 8 1968		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 8 Film 403 8-20-68 at												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last WILLIAM M. SNEED						2a. DATE OF DEATH 7 Month 14 Day 68 Year			2b. HOUR 19:45M			
3 SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 11 AUG 1925			6. AGE (In years last birthday) 42 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ANNE ARUNDEL Md						
10. CITY OR TOWN OF DEATH ODENTON				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KIMBROUGH ARMY HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK			12b. KIND OF BUSINESS OR INDUSTRY FORT MEADE	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND 13b. COUNTY ANNE ARUNDEL				13c. CITY OR TOWN ODENTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 516 Prince Charles Ave				
14. FATHER'S NAME First Middle Last William M. Sneed						15. MOTHER'S MAIDEN NAME First Middle Last Adeline DECEASED Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				16b. SOCIAL SECURITY NO. 427-20-9081		17 INFORMANT Address Eileen Sneed 516 Prince Charles Ave						
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 303.9 acute alcoholism with blood alcohol level of 0.14 mg percent DUE TO, OR AS A CONSEQUENCE OF to the performance of (b) to the performance of DUE TO, OR AS A CONSEQUENCE OF (c) INDIVIDUAL FIGHT FLIGHT DURING PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 14 Jul 1968 to 14 Jul 1968 , that (I) (we) last saw the deceased alive on DOA 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE John W. Barnard						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 July 68				
22d. PHYSICIAN'S NAME (Type) JOHN W. BARNARD						22e. ADDRESS Kimbrough Army Hosp						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION (City or Town) (County) (State) Ft. Meyer arl. Va.					
24. FUNERAL DIRECTOR Beverley E. Hopping HOPPING FUNERAL HOME - Annapolis, Md.						25a. RECEIVED BY REGISTRAR JUL 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

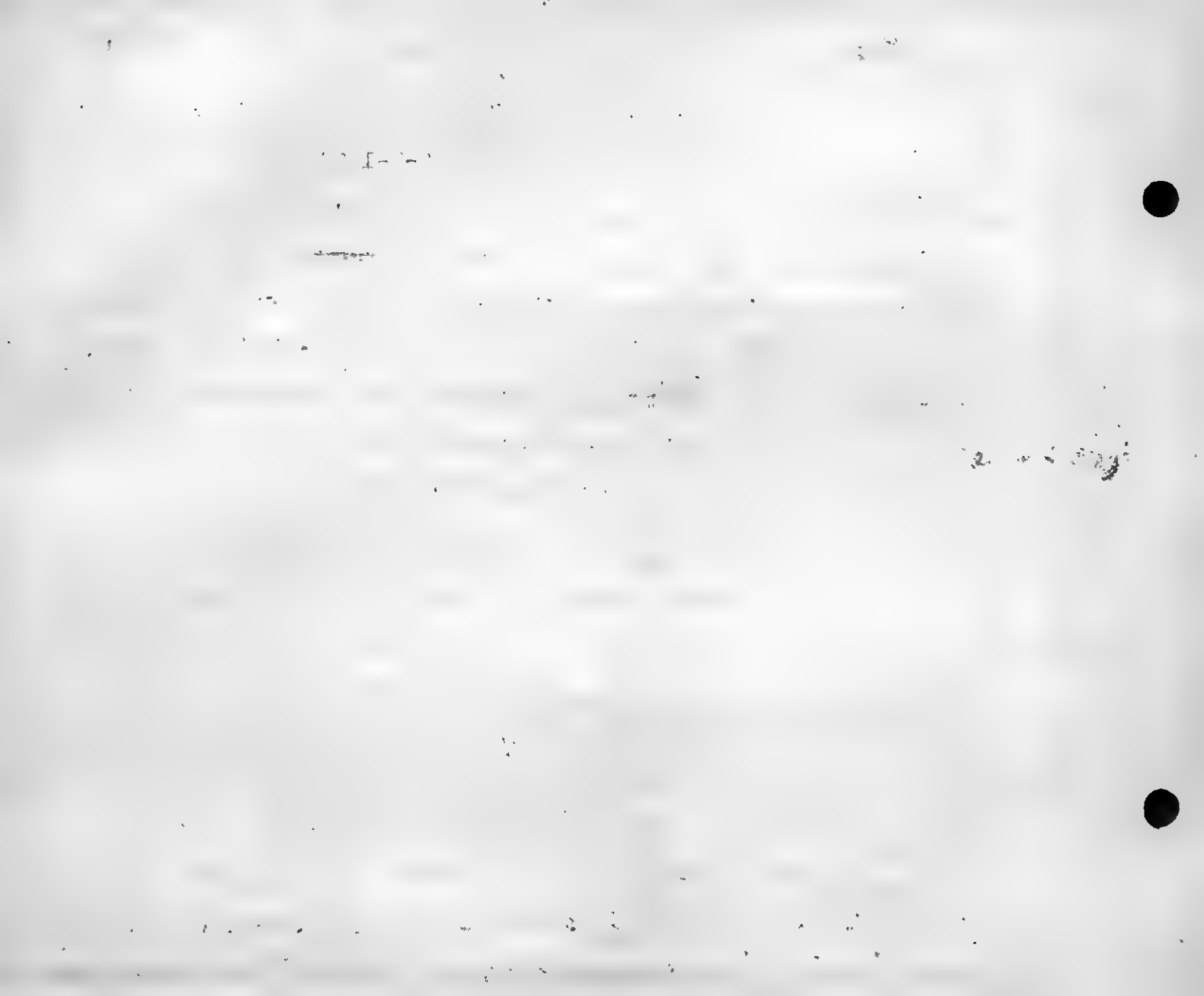
VR 15-54
304M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mary Alveta Snowden			2a. DATE OF DEATH Month 7 Day 28 Year 68			2b. HOUR 5:45a M					
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 1936 3-1-1936		6. AGE (In years lost birthday) 32 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Frederick, Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md					
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None				12b. KIND OF BUSINESS OR INDUSTRY 	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland				13b. COUNTY Frederick ✓		13c. CITY OR TOWN Frederick		13d. INSIDE CITY J.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt 6 Frederick Maryland	
14. FATHER'S NAME First Harry Middle NMN Last Snowden			15. MOTHER'S MAIDEN NAME First Mary Middle NMN Last Bowie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) unknown (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records, Crownsville, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Very Recent pulmonary embolism 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 465X (b) Moderate swelling both legs. DUE TO, OR AS A CONSEQUENCE OF (c) 											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Mental Deficiency											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 66 , to 7/ , 19 68 , that (I) (we) lost saw the deceased alive on 7/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles R. Venter, M.D.						22c. DATE SIGNED 7/29/68		22d. PHYSICIAN'S NAME (Type) Charles R. Venter, M.D.			
22e. ADDRESS Crownsville State Hospital, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 31-68		23c. NAME OF CEMETERY OR CREMATORY Bartonsville		23d. LOCATION (City or Town) (County) (State) Frederick - Fred. Md.					
24. FUNERAL DIRECTOR C.E. Hicks - Frederick - Md.		25a. REC'D BY REGISTRAR AUG 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR
Joseph Leo		Sovienski		Sovienski				Month 7 Day 3 Year 1968		P M
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month 7 Day 3 Year 1968	
M	W	Jul. 7, 1907		60 YRS					P M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Ohio		USA				Anne Arundel Co. Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Annapolis		D.O.A. - Anne Arundel Gen				handyman		Tavern		
13a USUAL RESIDENCE (Where deceased lived, if institution: Res. den. before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Maryland		A.A. CO		Herald Harbor				512 Cedar Trail		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last
Michael		Sovienski						Agnes		Rosemark
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		City, State		
no		217-32-3768		Raymond Wezik - Crownsville		P.O. Crownsville				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Caduce disease</u>										<u>Sudden</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION										20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		E. Linhardt		ADDRESS (Street, city, town, or county)		A.A. CO.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		July 6, 1968		St. Mary's Cemetery		Annapolis		A.A.		Md.
24. FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
Beverley E. Hopping		JUL - 8 1968		Charles Judge						
Hopping Funeral Home - Annapolis, Md.										



FOR STATE HEALTH DEPT.

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09444

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10452

1. DECEASED NAME (Type or Print) MICHAEL LYNN SPANN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 7 Day 3 Year 1968			2b. HOUR P.M.
3. SEX M	4. RACE N	5. DATE OF BIRTH MARCH 19, 1963	6. AGE (In years last birthday) 5 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS	8. UNDER 24 HRS HRS MIN.	2c. DATE PRONOUNCED DEAD Month 7 Day 3 Year 1968
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH M.A.CO
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.M. - Anne Arundel Gen		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE New Jersey		13b. COUNTY CUMBERLAND		13c. CITY OR TOWN Bridgeton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First WOODROW Middle SPANN Last CLARK		15. MOTHER'S MAIDEN NAME First K. Catherine Joyce Middle CLARK Last CLARK		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		
16b. SOCIAL SECURITY NO. NONE		17. INFORMANT SALLY Broughton ADDRESS 10300th AVE BRIDGETON, New Jersey				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fall from DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year PM 7-3 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto accident		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, off building, etc.) Highway		21f. LOCATION Street or R.F.D. No. City or Town County State Route 50 P.A.C.O. MD		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE E. Linhardt		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 7-3-68		
EXAMINER'S NAME (Type) E. Linhardt		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town or county) ANAPOLIS				
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE Jul 8, 1968		23c. NAME OF CEMETERY OR CREMATORY Rock Hill		23d. LOCATION (City or Town) (County) (State) Jacksonville Talbot Co GA
24. FUNERAL DIRECTOR Charles F. Bell Jr		ADDRESS Hopping FUNDAL Home ANNAPOLIS, Md.		25a. REC'D BY REGISTRAR DATE JUL - 8 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First <i>RONALD</i>		Middle <i>SPANN</i>		Last <i>SPANN</i>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>7</i> Day <i>3</i> Year <i>1968</i>	
3 SEX <i>M</i>	4 RACE <i>N</i>	5 DATE OF BIRTH <i>Oct. 8, 1960</i>		6 AGE (in years last birthday) <i>7</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>		2c. DATE PRONOUNCED DEAD Month <i>7</i> Day <i>3</i> Year <i>1968</i>	
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Anne Arundel Co</i>				
10 CITY OR TOWN OF DEATH <i>Annapolis</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Don - Anne Grundel Gen.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>New Jersey</i>		13b. COUNTY <i>Cumtberland</i>		13c. CITY OR TOWN <i>Bridgeton</i>		13d. RESIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>88 Pine Street</i>		
14 FATHER'S NAME First <i>Woodrow</i> Middle <i>SPANN</i> Last <i>CLARK</i>			15 MOTHER'S MAIDEN NAME First <i>Catherine Joyce</i> Middle <i>CLARK</i> Last <i>CLARK</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>Sally Broughton 10 South Ave. Bridgeton, New Jersey</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Injuries</i> <i>199</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>40 mins</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>7-3 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Auto accident</i>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>		21f. LOCATION Street or RFD No. <i>Route 50</i>		City or Town <i>MD</i>		County <i>MD</i>		State <i>MD</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>E. Linhardt</i>		EXAMINER'S NAME (Type) <i>E. Linhardt</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>7-3-68</i> <i>AACD</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>Jul. 8, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rockhill</i>		23d. LOCATION (City or Town) <i>Jacksonville</i>		(County) <i>Telfair</i>		(State) <i>GA.</i>
24. FUNERAL DIRECTOR <i>Charles F. Bell Jr.</i>				ADDRESS <i>Hopping Funeral Home Annapolis, Md.</i>		25a. REC'D BY REGISTRAR <i>JUL - 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

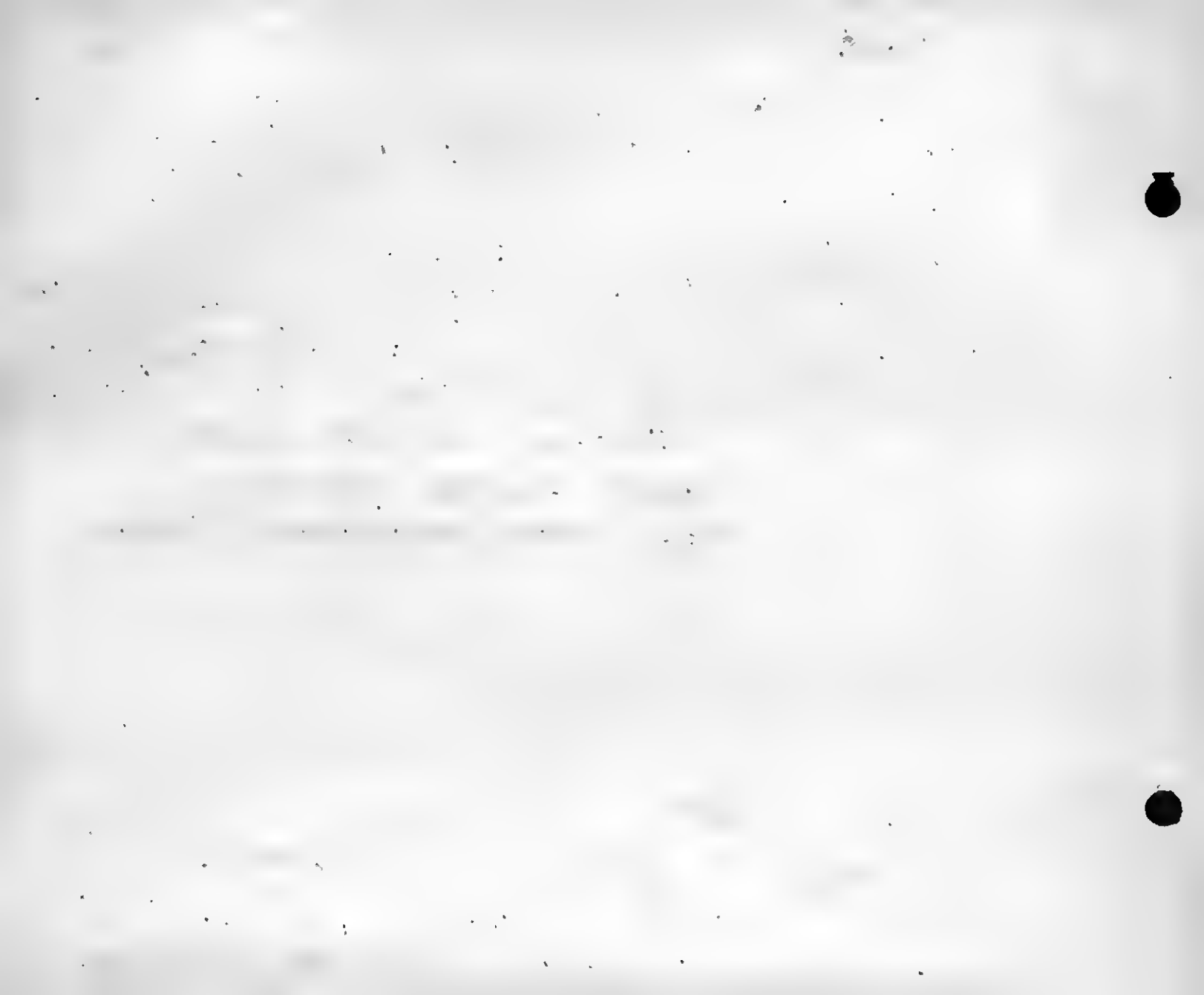


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Lawrence Spencer</i>			2a. DATE OF DEATH <i>7</i> Month <i>11</i> Day <i>1968</i> Year			2b. HOUR <i>M</i>					
3 SEX <i>Male</i>		4 RACE <i>Colored</i>		5. DATE OF BIRTH <i>5-10-1913</i>		6. AGE (in years last birthday) <i>55</i> YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Al. Al.</i> Md.					
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>A. A. General</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Al. Al.</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>128 Bestgate Rd.</i>			
14. FATHER'S NAME First <i>Thomas</i> Middle <i>Spencer</i> Last			15. MOTHER'S MAIDEN NAME First <i>Sue</i> Middle <i>Prindle</i> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT <i>Annie Spencer</i> Address <i>Annapolis</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest acute</i> <i>4120</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>acute Cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive Cardiovascular Disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ann T. Allen</i>			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>7-12-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>ANIS T. ALLEN</i>			22e. ADDRESS <i>62 Cathedral Dr</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>7-15-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		23d. LOCATION (City or Town) <i>Annapolis</i> (County) <i>Md.</i> (State)					
24. FUNERAL DIRECTOR <i>William Reese</i>			ADDRESS <i>Annapolis</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00447		00455	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH ASN 33-181-333															
DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		ESTIMATED		Month Day Year		2b HOUR	
HALSON W. STAFFORD		Helson		STAFFORD		SR		DATE KNOWN OF DEATH		ESTIMATED		7 1 68		A M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
M		W		23 Nov. 1912		55 YRS		MONTHS		DAYS		Month 7 Day 1 Year 68		A M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH							
MARYLAND		USA		WIDOWED		DIVORCED		A.A.CO.						Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of last year)		12b KIND OF BUSINESS OR INDUSTRY									
CROWNSVILLE		Crownsville State Hosp.		VETERINARY		TECHNICIAN									
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER							
MD.				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1417 GREGOR WAY							
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last	
HALSON W. STAFFORD		HALSON W. STAFFORD		BESSIE MARGARET WICKE											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS									
YES		WW II		220-03-6273		VELMA M. STAFFORD		AS ABOVE							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Hanging</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <u>933X</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
974X															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)											
		HOUR AM PM 7-1 1968		Injury self inflicted from Pipe											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State					
		Hospital & Warehouse						BACCO MD							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASS STANT MED. CA. EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED							
EXAMINER'S NAME (Type)		E. Linhart		ADDRESS (Street, city, town, or county)				7-1-68							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)					
BURIAL		7/5/1968		BALTIMORE NATIONAL		BALTIMORE, MD.									
24 FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
W. BROOKS BRADLEY		DUNDALK, MD.		JUL - 3 1968		Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOUR	
Fred C. Steinitz								7-5-68		7 PM	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS.		
M	W		4-27-1890		78 YRS.		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore		U.S.A.				Anne Arundel		Md.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
mellersville		Fuellwood Manor		Driller		Md. Drydock					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
md		Anne Arundel Friendship									
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Oscar		Steinitz						Pauline		Leidger	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?		16b SOCIAL SECURITY NO		17 INFORMANT		Address					
No		214-03-2251		Mr. Emil P. Walke		Friendship, Md. 20758					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure											
DUE TO, OR AS A CONSEQUENCE OF (b) C.C.V. & Pulmonary											
DUE TO, OR AS A CONSEQUENCE OF (c) Sinsuffic & Sen Corconomolosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
7221											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		Street or R.F.D. No.		City or Town		County	State
22a I certify that (I) (this hospital) attended the deceased from 1965, 19, to 1968, 19, that (I) (we) last saw the deceased alive on 7-4-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		22c DATE SIGNED									
Robert R. HAAN MD		7-5-68									
22d PHYSICIAN'S NAME (Type)		22e ADDRESS									
Robert R. HAAN		P.O. Box 73 Severna Park Md									
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		7/9/68		Cedar Hill		Ritchie Hwy		Anne Arundel		Co	
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
McCully F. H.		237 Patapsco Ave. 21225		JUL - 9 - 1968		Charles Judge					

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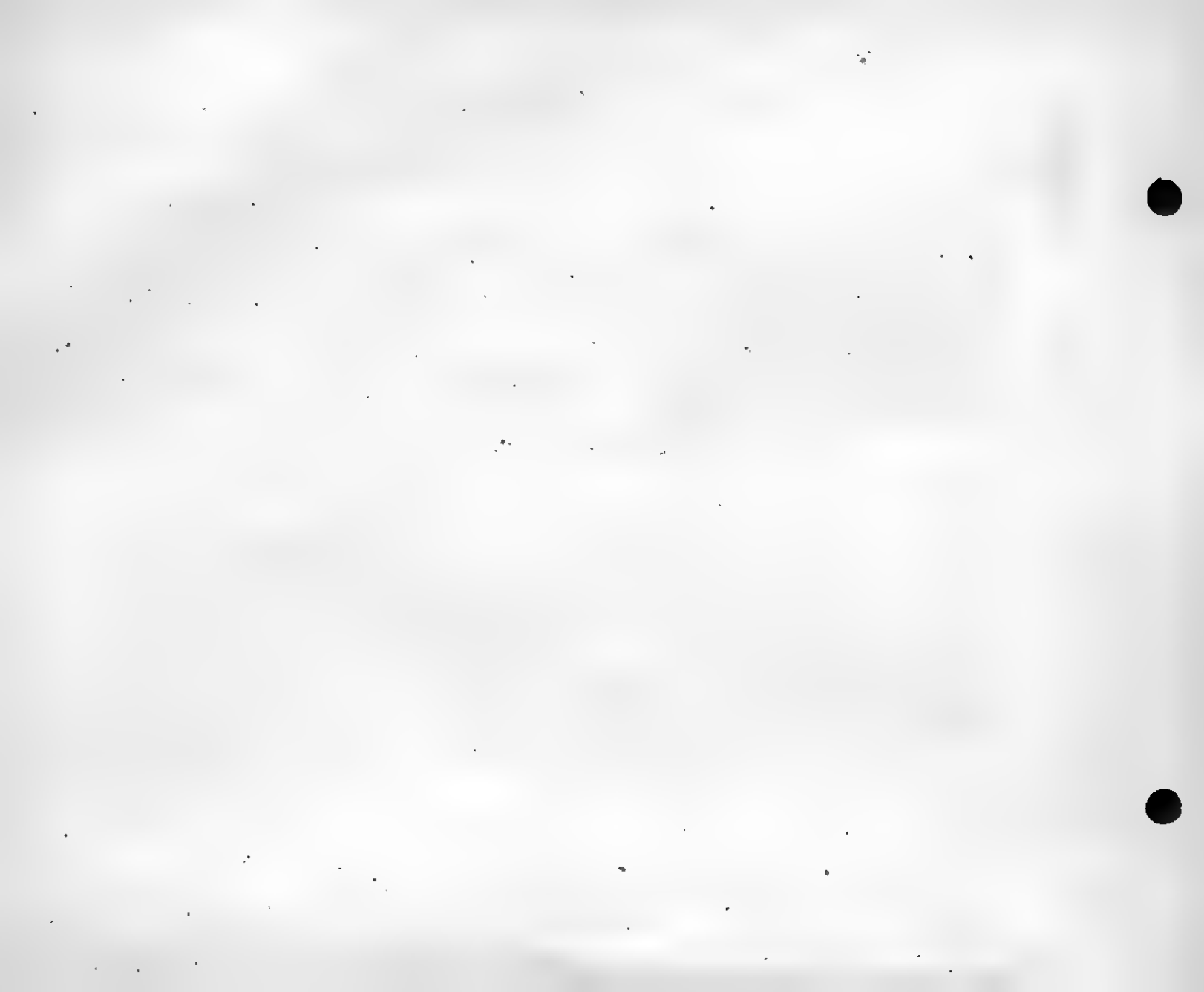
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

20157

1. DECEASED-NAME (Type or print) JEANNETTE P. STERLING			2a. DATE OF DEATH Month 7 Day 27 Year 68		2b. HOUR A M.
3. SEX F	4. RACE W	5. DATE OF BIRTH 3-7-1898		6. AGE (in years last birthday) 70 YRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ANNE ARUNDEL Md.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREENBRIAR LANE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) REAL ESTATE	12b. KIND OF BUSINESS OR INDUSTRY AGENT	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE MD.	13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER GREENBRIAR LANE	
14. FATHER'S NAME First Middle Last GEORGE H. STERLING		15. MOTHER'S MAIDEN NAME First Middle Last EVELYN D. JONES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT CARRIE S. LINHARDT - BOUCHER AVE. ANNAPOLIS MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancerous Reckline 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 154					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1966 , 19 7/27 , 19 68 , that (I) (we) last saw the deceased alive on 7/27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. Linhardt		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/27/68	
22d. PHYSICIAN'S NAME (Type) E. LINHARDT		22e. ADDRESS Chapin Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-30-68	23c. NAME OF CEMETERY OR CREMATORY CEDAR BLVD		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS A.A. MD.	
24. FUNERAL DIRECTOR John M. Taylor		ADDRESS ANNAPOLIS, MD.		25a. REC'D BY REGISTRAR JUL 30 1968	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Amy Emelia STEVENS			2a. DATE OF DEATH Month July Day 3 Year 1968			2b. HOUR P. 8:10 M				
3 SEX Female		4. RACE White		5 DATE OF BIRTH Feb. 12, 1890		6 AGE (in years last birthday) 78 YRS		7 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Anne Arundel Md				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 54 Madison Place	
14. FATHER'S NAME First J. Augusta Middle Farrell Last Farrell			15 MOTHER'S MAIDEN NAME First Christine Middle Linden Last Born							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown No (1 yes give war or dates of service)			16b. SOCIAL SECURITY NO. 4109		17. INFORMANT Address J. FRANKLIN STEVENS JR. #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) many years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Atrial fibrillation, congestive heart failure, metastatic breast carcinoma										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) this hospital attended the deceased from July 1967 , 19 68 , to 3 July , 19 68 , that (I) was lost saw the deceased alive on 3 July , 19 68 , and that in (my) post post apianian death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.										
22b. SIGNATURE Charles W. Kinzer				DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5 July 1968				
22d. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.				22e. ADDRESS 16 Murray Ave., Annapolis, Md.						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 7-6-68		23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION (City or Town) (County) (State) Annapolis AA. MD.				
24. FUNERAL DIRECTOR John M. LaSalle				ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

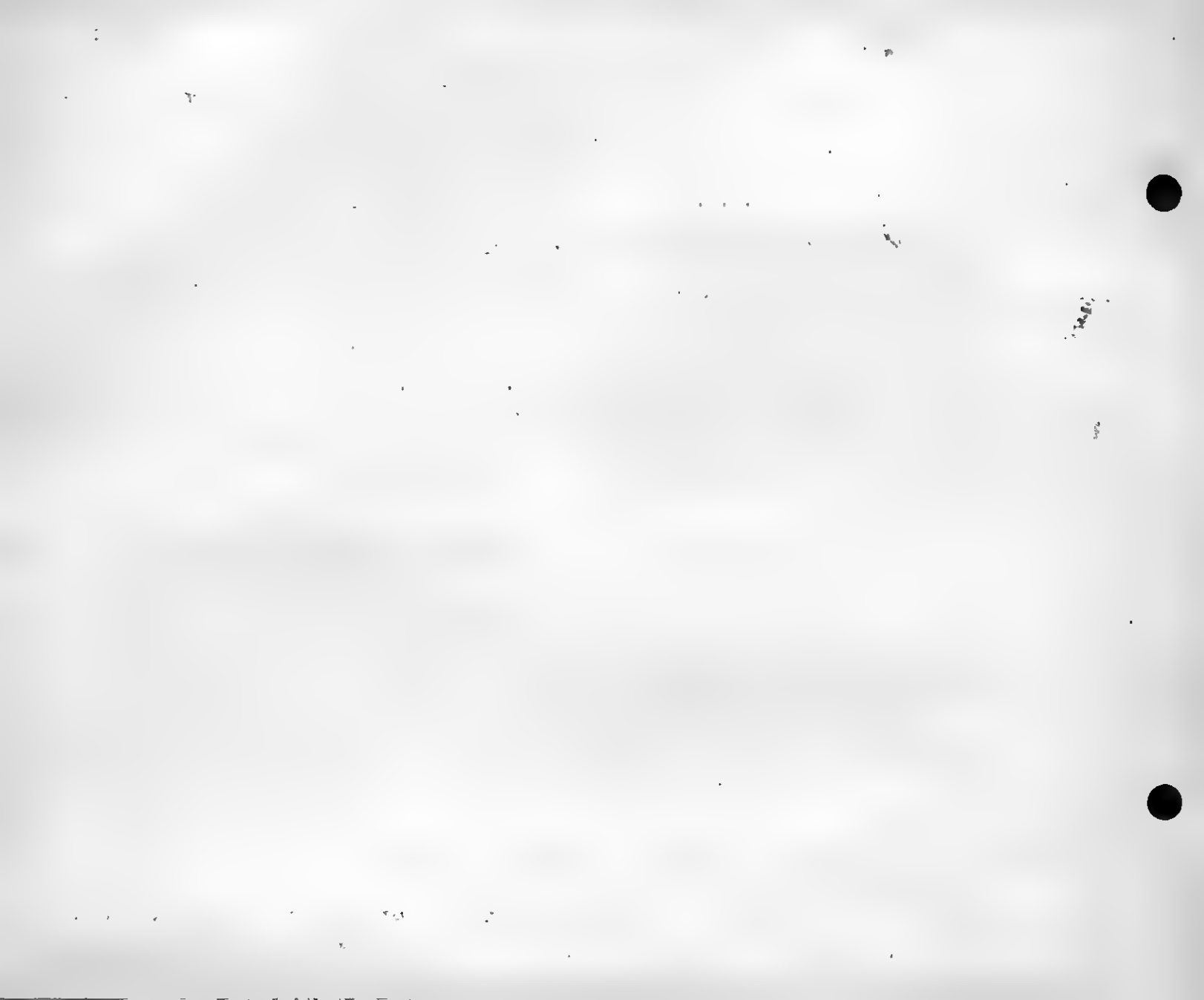


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b HOUR	
John		J	stierstorfer		7 30		19	68	P	M	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD		
M	W	11-8-1904		63 YRS	MONTHS DAYS		HOURS MIN.		2d HOUR		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			
Maryland		U.S.A.				Anne Arundel		Brooklyn Park			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	
932 First Street		Printer				MD		aa		Brooklyn Park	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS	
George Stierstorfer		Mary Hoffman		Yes		217-03-2698		Mr. David P. Anderson		1219 Poplar Ave. 21227	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular disease.</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
7 30											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)			
				19 P.M.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Wetner J. Spitz</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) <u>Wetner J. Spitz</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				8.3.68			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
BURIAL		8-5-1968		Meadowridge Cemetery		Howard County, Maryland		DATE AUG 5 1968		J Charles Judge	
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard, 4107 Wilkens Ave. 21229								DATE AUG 5 1968		J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>35452</div> <div>CERTIFICATE OF DEATH</div>											
1. DECEASED-NAME (Type or print)			First FELIX			Middle STONE			Last STONE		
2a. DATE OF DEATH			JULY			Month 19			Day 1968 Year		
2b. HOUR			2:05			M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		F UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		March 21, 1898		70 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
Kentucky		USA		WIDOWED		DIVORCED		Anne Arundel		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Fort George G. Meade			U.S. Kimbrough Army Hosp			Serviceman (retired)			U.S. Army		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Anne Arundel			Linthicum			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER			13f. STREET AND NUMBER			13g. STREET AND NUMBER			13h. STREET AND NUMBER		
112 N. Orchard Road			112 N. Orchard Road			112 N. Orchard Road			112 N. Orchard Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT		
James Calvin Stone			Telia Patterson			213-28-2135			Mrs. Felix Stone, Same as item # 13		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes			1917 - 1946			213-28-2135			Mrs. Felix Stone, Same as item # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>HYPERCALCEMIC COMA</u>										4 weeks	
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>METASTATIC CARCINOMA</u>										4 weeks	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>CARCINOMA OF LUNG</u>										4 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Yes		
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			HOUR A.M. Month Day Year								
(If either, notify medical examiner)			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town		
While <input type="checkbox"/> Not while <input type="checkbox"/>						Street or R.F.D. No.			County		
at work <input type="checkbox"/> at work <input type="checkbox"/>						City or Town			State		
22a. I certify that (I) (this hospital) attended the deceased from <u>22 June</u> , 19 <u>68</u> , to <u>19 July</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19 July</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
<u>Joseph I. Krall, M.D.</u>			19 July 1968			JOSEPH I. KRALL, 1st Lt, MC			U.S. KIMBROUGH ARMY HOSP, FT MEADE, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			7/23/68			Arlington Nat'l Cemetery			Fort Myer, Va.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REG. STRAR'S SIGNATURE					
<u>Robert P. W...</u>			JUL 22 1968			<u>Charles Judge</u>					
Singleton Funeral Home			Glen Burnie, Md.								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

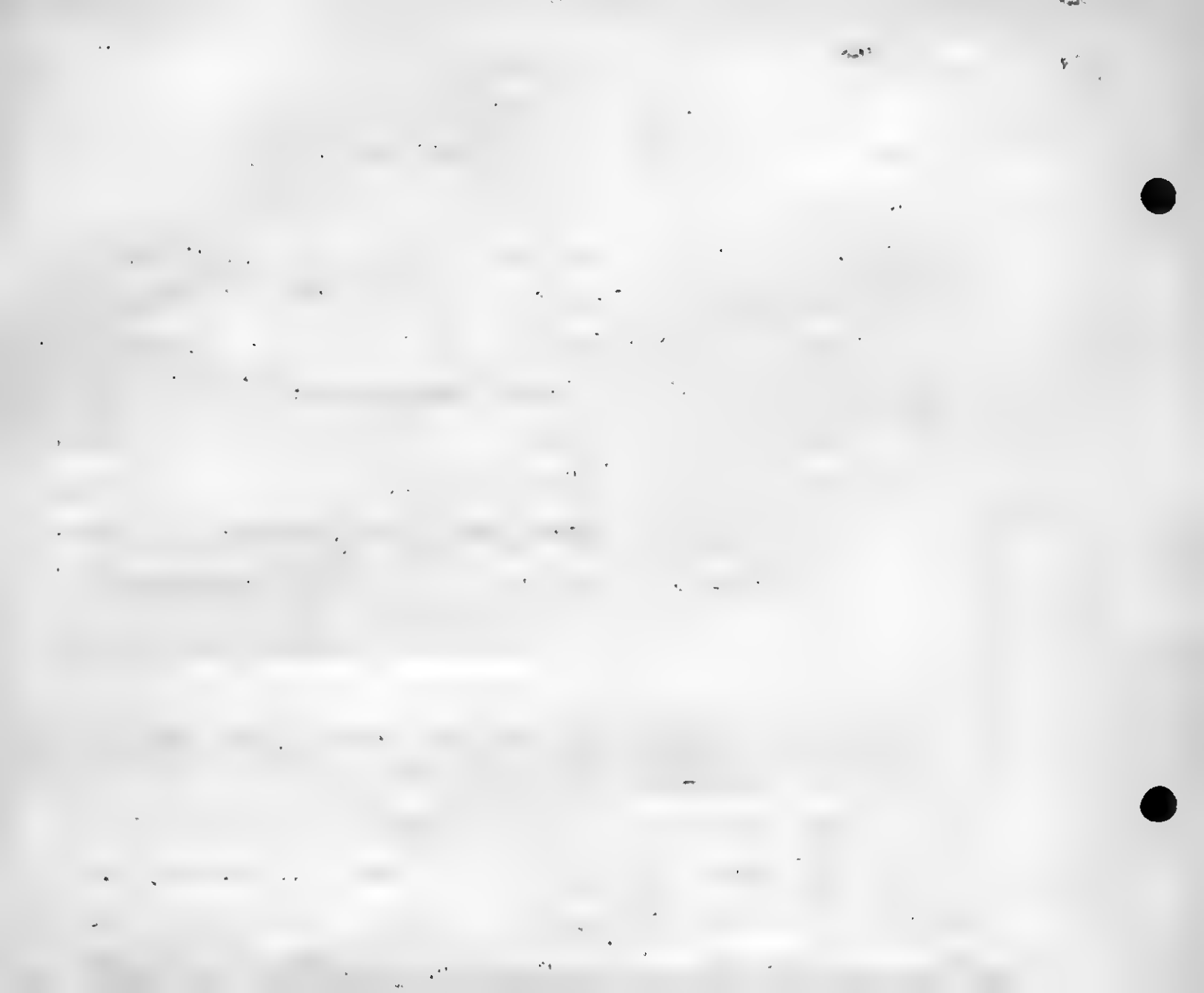
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00461

1. DECEASED-NAME (Type or print) First Middle Last Lester Arthur STOFFER			2a. DATE OF DEATH Month Day Year July 18 1968			2b. HOUR 9:40 M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JUNE 16-1907		6. AGE (in years last birthday) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md			
10. CITY OR TOWN OF DEATH ANNAPOLIS, MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ANNE ARUNDEL HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) MAINTENANCE MAN		12b. KIND OF BUSINESS OR INDUSTRY ELIZABETH TOWN MASCAL Homes			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE PA.		13b. COUNTY LANCASTER		13c. CITY OR TOWN ELIZABETHTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 463 W. BAINBRIDGE ST.	
14. FATHER'S NAME First Middle Last IRA - STOFFER			15. MOTHER'S MAIDEN NAME First Middle Last BERTHA - GARDENHOUR						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 195-07-0780		17. INFORMANT MRS Mary E Stauffer 463 West Bainbridge St Elizabeth town, Pa					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock. 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arbythmia DUE TO, OR AS A CONSEQUENCE OF (c) Arterial valve coronary disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Hours Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1) Pneumonia heart disease 2) arterial disease 3) pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2/17 , 19 68 , to 7/17 , 19 68 , that (I) (we) last saw the deceased alive on 2/17 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE General Church				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/18/68			
22d. PHYSICIAN'S NAME (Type) GERARD CHURCH				22e. ADDRESS 121 Cathedral St., Annapolis, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE July 22-68		23c. NAME OF CEMETERY OR CREMATORY Rolling Green Cemetery		23d. LOCATION (City or Town) (County) (State) CAMP HILL CUMBER PA.			
24. FUNERAL DIRECTOR David L. Musselman				25a. RECO BY REGISTRAR JUL 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH																										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																										
CERTIFICATE OF DEATH																										
1. DECEASED NAME (Type or print)			First Susie			Middle Virginia			Last SUITT			2a. DATE OF DEATH Month July			Day 8,			Year 1968.			2b. HOUR 2:10			A.M. M.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH June 28, 1880			6. AGE (In years last birthday) 88			YRS			IF UNDER 1 YEAR MONTHS			DAYS			IF UNDER 24 HRS. HOURS			MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH Anne Arundel County,			Md.														
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) H.A. GENERAL Hospt.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOME			12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE																	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD.			13b. COUNTY H.A. ANNAPOIS			13c. CITY OR TOWN ANNAPOIS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 307 N. WOODLAWN AVE.														
14. FATHER'S NAME First SAMUEL			Middle C.			Last BYBHEN			15. MOTHER'S MAIDEN NAME First SUSIE			Middle REBECCA			Last PURDY											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not (if unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO —			17. INFORMANT Mrs. ERNEST DONALDSON			Address #13																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis and Myocardial infarction</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4220</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 YRS.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Congestive Heart Failure; Arteriosclerosis</u>																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																				
22a. I certify that (I) (this hospital) attended the deceased from June 7, 1968 to July 8, 1968, that (I) (we) last saw the deceased alive on July 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE Edward S. Beck			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 7/8/68																	
22d. PHYSICIAN'S NAME (Type) EDWARD S. BECK			22e. ADDRESS Franklin St. Annapolis, MD.																							
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE 7-10-68			23c. NAME OF CEMETERY OR CREMATORY Mayo Memorial			23d. LOCATION (City or Town) (County) (State) Mayo A.A. MD.																	
24. FUNERAL DIRECTOR John M. L. Roberts			ADDRESS Annapolis, Md.			25a. REC'D BY REGISTRAR DATE JUL 12 1968			25b. REGISTRAR'S SIGNATURE Charles Judge																	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div> <div>33455</div> <div>CERTIFICATE OF DEATH</div> </div>									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Margaret			M. Swanke			7 Month 28 Day 68 Year			7P M
3. SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR
Female		White		12-31-90			77 YRS.		MONTHS DAYS HOURS M N
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Balt., Md.		United States		Anne Arundel					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Glen Burnie,			North Arundel Hospital			Housewife			
13a. JS.JA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Balt., Md.			Balt.			#8 E. Bend Court Apt.C			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
John Gibbons			Margaret Quinn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address
216-03-5036 D			Mrs. Margaret S. Long			Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> 4127 DUE TO, OR AS A CONSEQUENCE OF (b) <u>intermediate cardiovascular lesion</u> 4221 DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
7-22-68		Gangrene R leg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21c. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7-12, 1968, to 7-28, 1968, that (I) (we) last saw the deceased alive on 7-28-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James H. Coleman MD</u>					22c. DATE SIGNED 7-28-68				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		July 31, 1968		Glen Haven Mem. Pk.			Glen Burnie, Maryland		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George J. Gonce 4001 Ritchie Hwy. Balto. Md.					AUG 1 1968		<u>Charles Judge</u>		

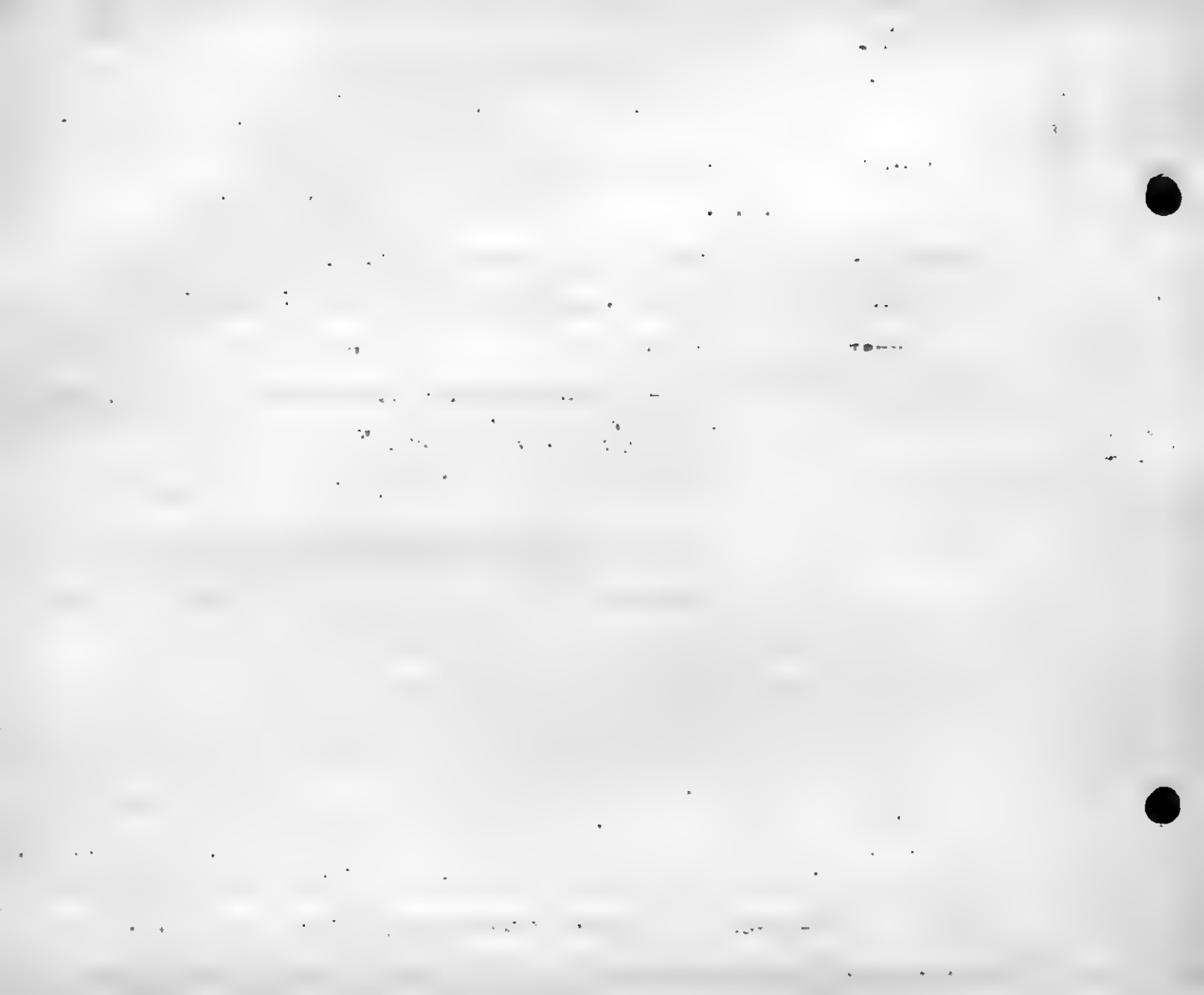


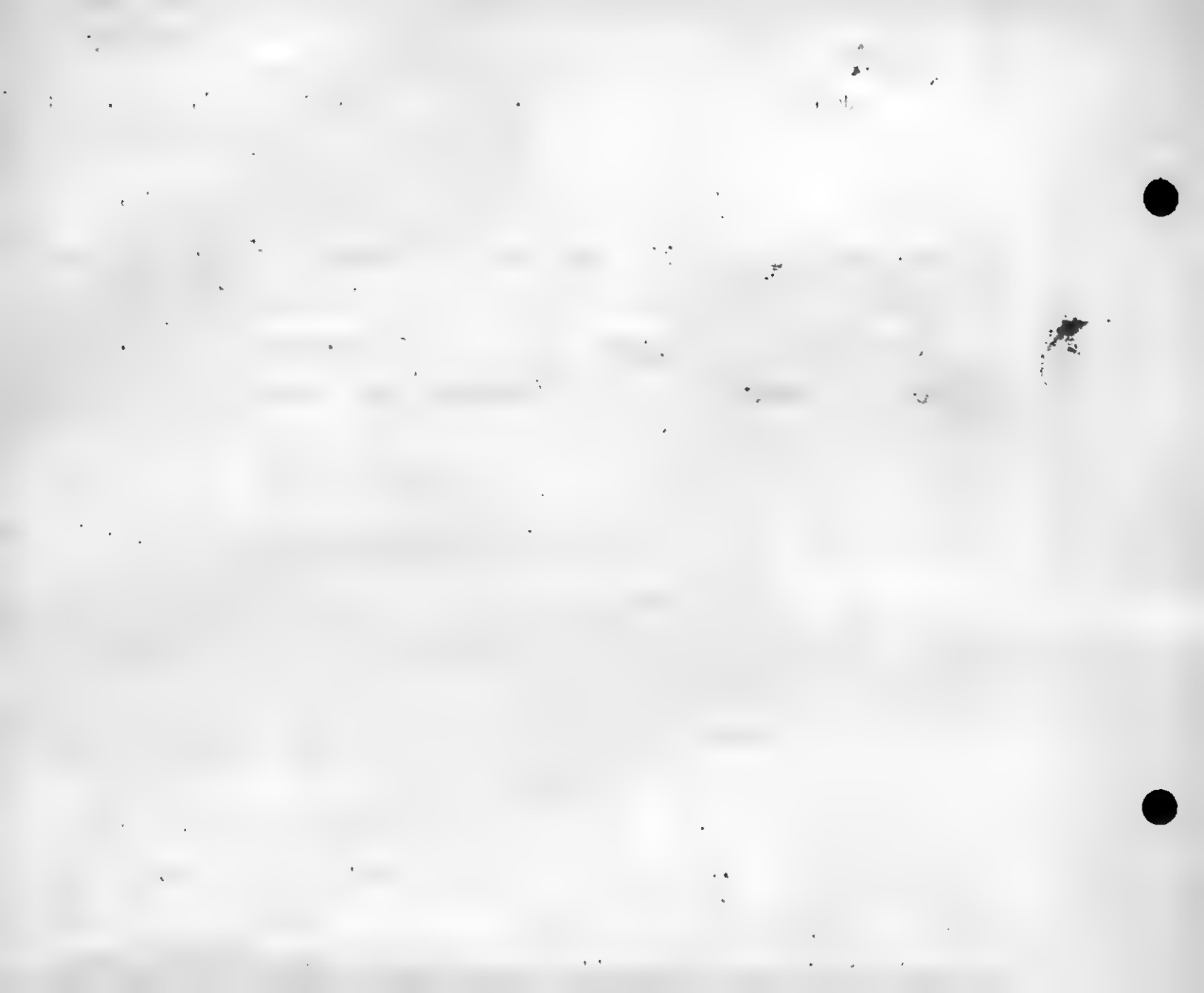
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VR 1515
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
39456 . 3464 CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Edna Helen SWANN						July 20 1968			10:50 AM
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (in years last birthday)		7 UNDER 1 YEAR MONTHS DAYS	7 UNDER 24 HRS. HOURS MIN
Female	Negro		7-7-1894			74 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md		U.S.A.				Anne Arundel Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Annapolis			Anne Arundel Gen			Housekeeper		*****	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md			Anne A. Annapolis			1983 West St			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Ignathus Nathaniel Washington			Winnie Ann Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown)			16b SOCIAL SECURITY NO			17 INFORMANT Address			
No			214-05-2328			Jeremiah S. Swann 1983 West St. Anne, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast & Metastasis 2 Yr.</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 8-4-1968 to 7-20-1968, that (I) (we) last saw the deceased alive on 7-18-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Frank M. Shipley MD</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 7-26-68		
22d PHYSICIAN'S NAME (Type) <u>F.M. SHIPLEY</u>					22e ADDRESS <u>121 Cathedral St. Annapolis, Md.</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		7-23-68		Pinlawn Memorial Pk		Annapolis A.A. Md			
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
C.E. Hicks, 111 Annapolis, Md					JUL 26 1968		J Charles Judge		



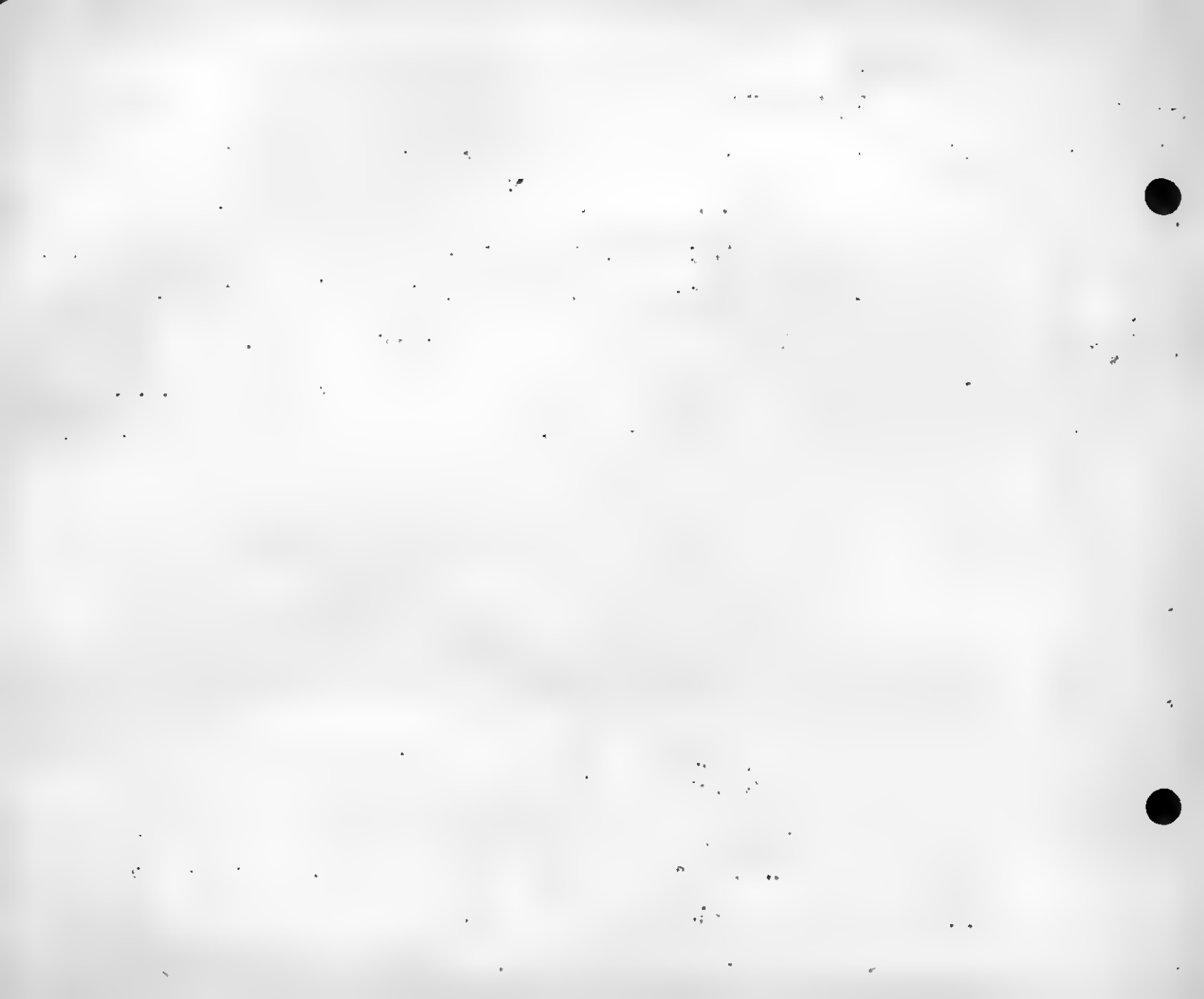


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 8466
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) JOHN LADD TAGGART			2a. DATE OF DEATH Month JULY Day 15 Year 1968			2b. HOUR 8:05 AM				
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH 19 May 1931		6. AGE (in years lost birthday) 37 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL Md.				
10. CITY OR TOWN OF DEATH FT GEO G MEADE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NATIONAL SECURITY AGENCY		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ANALYST		12b. KIND OF BUSINESS OR INDUSTRY US GOVT				
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE MARYLAND			13b. COUNTY PRINCE GEO		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5611 HAMILTON ST	
14. FATHER'S NAME First Middle Last ARCH D TAGGART			15. MOTHER'S MAIDEN NAME First Middle Last LAVANGE M. GARY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 371-30-8807		17. INFORMANT Address Medical & Personnel Records, N.S.A.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) PROBABLE MASSIVE CORONARY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>no prev knowledge</u> to _____, 19____, that (I) (we) last saw the deceased alive on <u>15 Jul 68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Warren G. Preisser</i>					22c. DATE SIGNED 16 JUL 68					
22d. PHYSICIAN'S NAME (Type) WARREN G. PREISSER					22e. ADDRESS NSA Medical Center, Ft Geo G Meade, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Cement City Cemetery		23d. LOCATION (City or Town) (County) (State) Jackson Michigan				
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR JUL 19 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

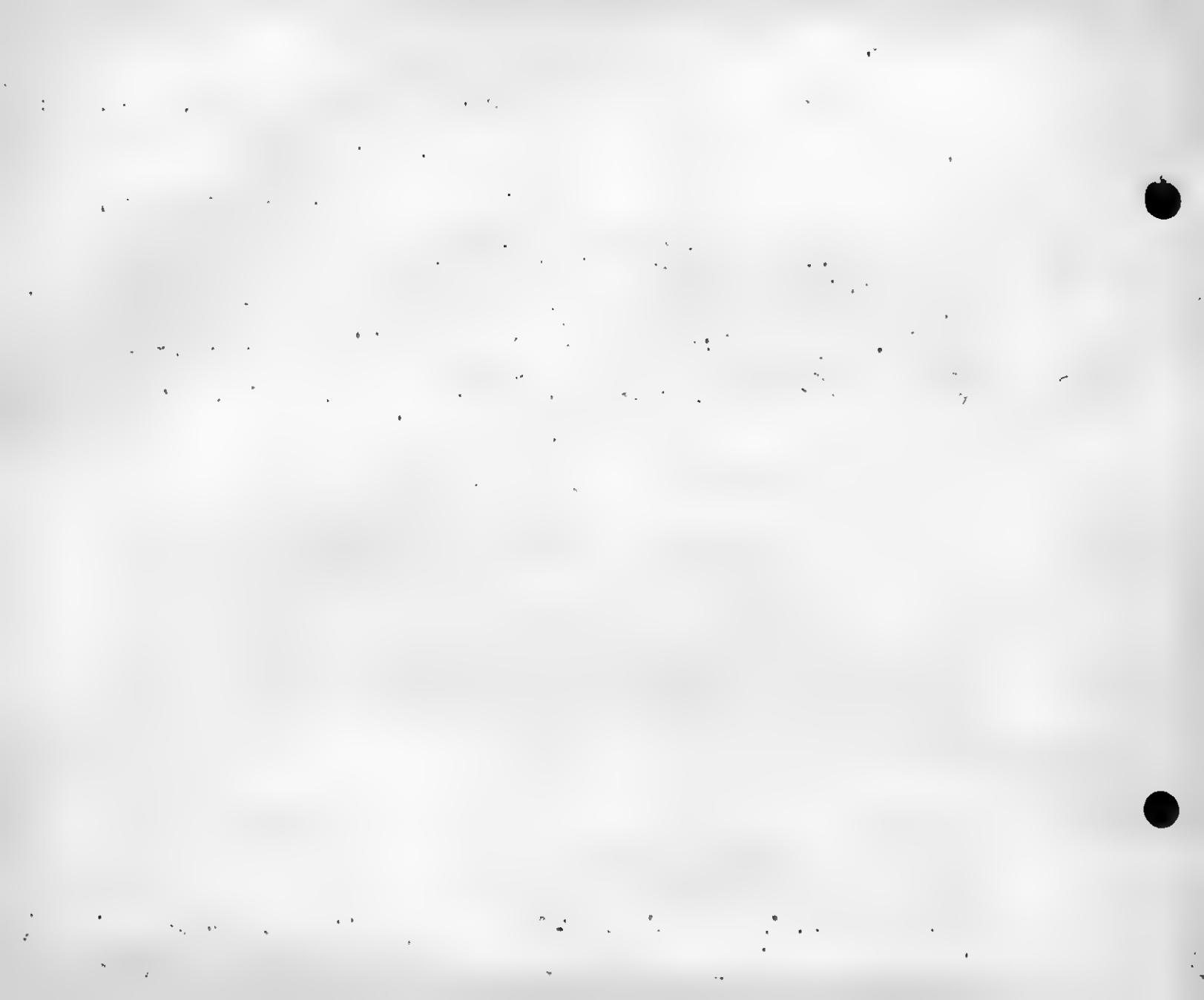


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
00459													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Bessie			TAYLOR			July Month 27, Day 1968. Year			10:55				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Col.		11/15/1931			36 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Md. U.S.A.			U.S.A.						Anne Arundel County,			Md.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done within most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis				U. S. General Hosp. (Bessie)								Sundry	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE				13b. COUNTY				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				U. S.				Annapolis		306 Chester Ave			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last				
James			Meade Sr.			Claradell			Simmons				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO				17. INFORMANT				Address	
No				212-34-6321				Samuel J. Taylor				306 Chester Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL EDEMA 4001 DUE TO, OR AS A CONSEQUENCE OF BLOOD LOSS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF REFUSAL OF Blood transfusion (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE William Womies DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			7/24/68			Fine Lawn			Annapolis U. S. Md.				
24. FUNERAL DIRECTOR William Reese II - Anna. Md. ADDRESS								25a. JUL 29 1968 DATE		25b. REGISTRAR'S SIGNATURE			



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 4, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundle		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey		c. LENGTH OF STAY IN 1b 8 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt #2 Box 22 Hanover Md.				d. STREET ADDRESS Rt #2 Box 22 Hanover Md.		e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Milton Taylor		First Middle Last		4. DATE OF DEATH July 9, 1968		Month Day Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 8, 1882		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Anne Arundle Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Taylor				14. MOTHER'S MAIDEN NAME Mary Chancey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-22-4915-J 1-		17. INFORMANT Mrs. Mary V. Hebron-Rt. 2 Box 22-Hanover Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> DUE TO (b) <i>Hypertension with cardiac involvement</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 17, 1968 to July 19, 1968, that (I) (we) last saw the deceased alive on Jan 17, 1968, and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Frank E. Shipley, M.D.				22b. DATE SIGNED July 15, 1968		22c. PHYSICIAN'S NAME (Type) Frank E. Shipley, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/12/68		23c. NAME OF CEMETERY OR CREMATORY Saints Rest Cemetery		23d. LOCATION (City, town or county) (State) Anne Arundle Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter-3025 W. North Ave.				25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE Johnas J...	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09461

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09469

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF EST- DEATH MATED		Month	Day	Year	2b HOUR
MARY AGNES TONGUE					7 19 1968					A M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD Month		2d HOUR
F	N	6-12-1888	80 YRS					7 Day 19 Year 1968		19 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md		U.S.A				Anne Arundel Co. Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis		DCA-ANNE ARUNDEL GEN		Domestic						
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md		A.P.		Annapolis				40 Pleasant Street		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
George			NMA	BRANDFORD	Julia			NMA	BROWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
NO		None		Bradley Tongue		40 Pleasant St. ANNA, Md				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerosis generalized</u> 4407 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 7-19-68 A.A. Co.				
EXAMINER'S NAME (Type)		F. Linhardt				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		7-23-1968		PINE LAWN MEMORIAL		Annapolis A.P. Co. Md				
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
C.E. Hicks, III		Annapolis, Md				JUL 26 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

89462

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

8470

1. DECEASED-NAME (Type or print) JOHN A. TRIPLETT JR.		First Middle Last		2a. DATE OF DEATH JULY Month 14 Day 1968 Year		2b. HOUR 0305 M	
3 SEX male		4 RACE Cau		5. DATE OF BIRTH January 14, 1935		6 AGE (In years last birthday) 33 YRS.	
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arrundel Md	
1d CITY OR TOWN OF DEATH Ft. Meade		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kimbrough Army Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Truck Driver		12b KIND OF BUSINESS OR INDUSTRY Industrial Supply	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Elkridge		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER Box 305R Rt. #4		14 FATHER'S NAME First Middle Last John A Triplett		15 MOTHER'S MAIDEN NAME First Middle Last Mary Virginia Sentz		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/>	
16b SOCIAL SECURITY NO 215-32-0025		17 INFORMANT Brother, Arthur W. Triplett		Address Saucier, Miss.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Damage DUE TO, OR AS A CONSEQUENCE OF (b) basilar skull Fracture DUE TO, OR AS A CONSEQUENCE OF (c) 8214	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Compound Fracture (R) TIBIA and Fibula							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Motorcycle Accident			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) STREET		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 13 Jul, 1968 , to 14 Jul, 1968 , that (I) (we) last saw the deceased alive on 14 Jul, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frank P. Rizzo				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) FRANK P. RIZZO				22e. ADDRESS US Kimbrough Army Hospital FCGM, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 17/68		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION (City or Town) (County) (State) Elkridge, RFD, Md.	
24. FUNERAL DIRECTOR R. Singleton				25a. REC'D BY REGISTRAR SINGLETON FUNERAL HOME		25b. REGISTRAR'S SIGNATURE GLEN BURNIE, MARYLAND	
				DATE JUL 17 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Page 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A.M.		
Kirby Leon TWITTY						July 5 1968			6:15 M		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS			
Male		White		Jan. 9, 1908		60 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
South Carolina		U.S.				Anne Arundel Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Annapolis			Anne Arundel Gen. Hops.			Mechanic		Auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Anne Arundel		Edgewater				Rt-2, Box-111		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
George						Sally					Plyler
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?			16b. SOCIAL SECURITY NO.			17. INFORMANT					
no			248-03-2043			Martha H. Twitty - same as #13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>										32 DAYS	
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>										10 YEARS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>4201</u> (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Cerebral Thrombosis & Stenoplegia</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1967</u> to <u>5 July, 1968</u> , that (I) (we) lost saw the deceased alive on <u>4 July, 1968</u> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death											
22b. SIGNATURE <u>Edward S. Beck</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>7/5/68</u>			
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.						22e. ADDRESS 73 Franklin St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Jul. 9, 1968		Hillcrest Cemetery			Annapolis A.A. Md.			
24. FUNERAL DIRECTOR Beverly E. Hopping HOPPING FUNERAL HOME - Annapolis, Md.						25a. REC'D BY REGISTRAR DA <u>MIL - 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

0472

1 DECEASED NAME (Type or print) Elizabeth		First	Middle	Last	2a. DATE OF DEATH Month July Day 21 Year 1968	2b. HOUR 11:00
3 SEX Female	4. RACE Negro	5. DATE OF BIRTH 7-18-1921			6. AGE (In years last birthday) 47 YRS	IF UNDER 1 YEAR MONTHS OAYS
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel		
10. CITY OR TOWN OF DEATH Glen Burnie,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Odenton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 386		
14. FATHER'S NAME First Benny Middle Parker Last Josephine	15. MOTHER'S MAIDEN NAME* First Contee Middle Contee Last Contee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO 212325964	17. INFORMANT Charles E. Parker Bowie Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertension (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 7-21-1968 , to 7-21-1968 , that (I) (we) last saw the deceased alive on 7-21-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Robert Daboliwski, MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 7-21-68	
22d. PHYSICIAN'S NAME (Type) ROBERT DABOLIWSKI, MD				22e. ADDRESS 400 CRAIN Hwy N W Glen Burnie Md		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-24-1968	23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City or town) (County) (State) Odenton Md		
24. FUNERAL DIRECTOR William Beese				25a. RECD BY REGISTRAR DATE JUL 23 1968		25b. REGISTRAR'S SIGNATURE Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

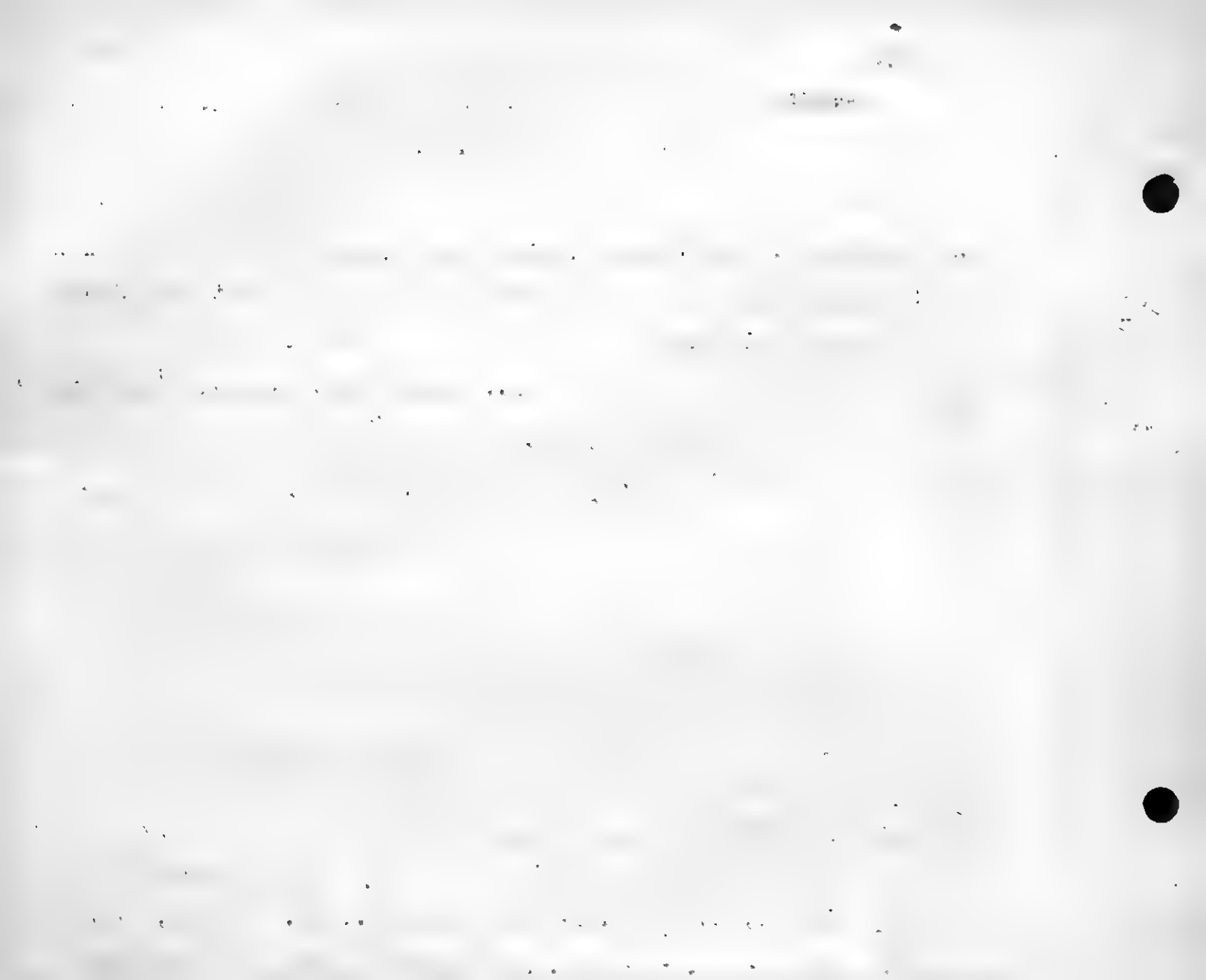
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
ETHEL				VICKERS	July 2, 1968		8:05 PM		
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female	White		Nov. 5, 1882		85 YRS.				
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland	USA				Anne Arundel Md				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
nr. Annapolis, Md.		Bay Manor Nursing Home		Housewife		--			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Jessup		YES		28 Montivideo Court	
14 FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
Joseph Solloway				Charlotte Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
No				Mrs. Charlotte Chokeley,		Glen Bernie,		Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unknown</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about 6 hours</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>301A</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/22/1963</u> to <u>7/2/1968</u> , that (I) (we) last saw the deceased alive on <u>May 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.									
22b. SIGNATURE <u>Richard I. Hochman, M.D.</u>					22c. DATE SIGNED <u>7/2/68</u>				
22d. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>					22e. ADDRESS <u>16 Murray Ave, Annapolis, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
burial		July 5, 1968		St. Georges Cemetery, St. Georges, Delaware					
24. FUNERAL DIRECTOR <u>John H. Taylor & Sons, Annapolis, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



38466

38474

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-105. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH: MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
DAWN R. Waddill						7 16 68			P M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
F	W	May 17, 1963	5 YRS	MONTHS	DAYS	HOURS	MIN	Month 7 Day 16 Year 68	2d HOUR P M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Anne Arundel CO Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		2b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		DOR-ANNE ARUNDEL GEN				None		USA	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
MD			-		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		2809 Myrtle NE
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First
Roy R. Waddill						Dorothy A. Turner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
No			None		Mrs. Dorothy A. Waddill (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)									
1100 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOURS 7/16 19 68		Drowning in Chesapeake Bay					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
		Chesapeake Bay		Chesapeake		Annapolis		Anne Arundel	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b. DATE SIGNED		7-16-68							
ACTUAL SIGNATURE		E. Linhardt							
EXAMINER'S NAME (Type)		E. Linhardt							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		7/20/68		Meadowridge Mem. Cem.		Elkridge, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc.		Balto. Md. 21214		JUL 18 1968		John J. Ruck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

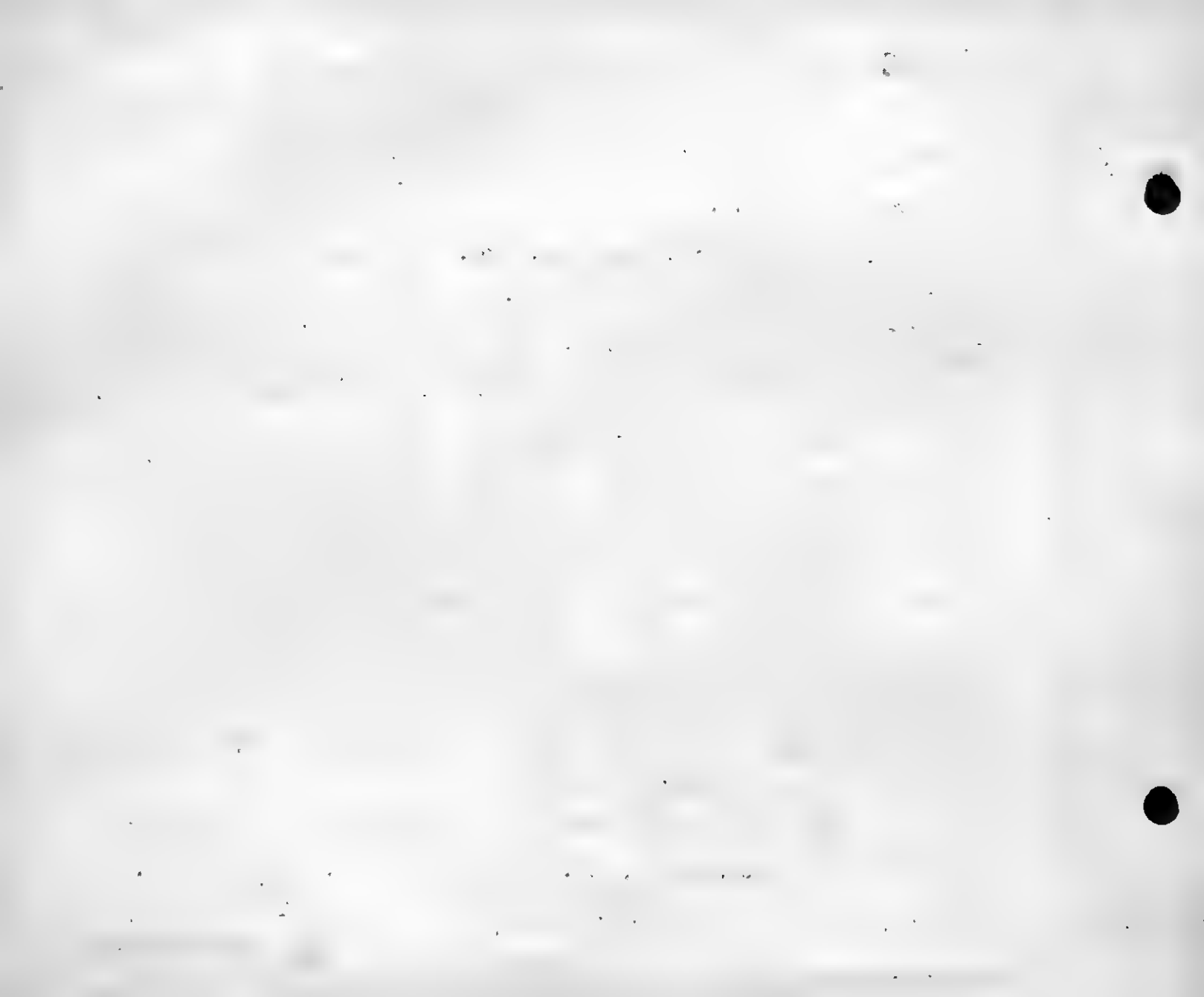
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
30467 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First JOHN		Middle M.		Last WAHL		2a. DATE OF DEATH Month Day Year JULY 9 1968		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 21, 1905			6. AGE (in years lost birthday) 62 YRS.		7b. HOUR 12 45 PM		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ANNE ARUNDEL			Md		
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WATCHMAN			12b. KIND OF BUSINESS OR INDUSTRY SANITATION DEPT			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN GLEN BURNIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 123 MARTHA ROAD			
14. FATHER'S NAME First Middle Last Francis Wahl			15. MOTHER'S MAIDEN NAME First Middle Last Guilfoy								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215-10-9867		17. INFORMANT Mrs. Wm. Langston			Address 123 Martha Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left Ventricular failure hours 2110 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) Septicemia, generalized hours noting the underlying cause (c) Delirium Tremens days										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bacterial pneumonia - fracture of acetabulum											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 6/25, 1968, to 7/1, 1968, that (I) (we) lost saw the deceased alive on 7/1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]		DEGREE MEDICAL DIRECTOR		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/1/68					
22d. PHYSICIAN'S NAME (Type) MAX C FRANK		22e. ADDRESS 4255 Ritchie Hwy, Glen Burnie MD									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION (City or Town) Glen Burnie, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. (21225)		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE [Signature]					

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Baby		First Middle Last		2a. DATE OF DEATH Month Day Year July 3 1968		2b. HOUR A.M. P.M. 2:55M	
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH July 2, 1968		6 AGE (In years last birthday) YRS MONTHS DAYS 7 1 40	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Newborn		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Lothian		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Middle Last Lloyd Wallace		15 MOTHER'S MAIDEN NAME First Middle Last Bladys Moulders		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	
17 INFORMANT Lloyd Wallace Lothian Md.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PREMATURITY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the doctor) attended the deceased from 7/2, 1968 , to 7/3, 1968 , that (I) (we) lost saw the deceased alive on 7/3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Jonathan McC. Sutton, M.D.				22c. DATE SIGNED 7/3/68		22d. PHYSICIAN'S NAME (Type) Jonathan McC. Sutton, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-7-68		23c. NAME OF CEMETERY OR CREMATORY Lothian		23d. LOCATION (City or Town) (County) (State) Lothian Md	
24. FUNERAL DIRECTOR William Brewster		25a. REC'D BY REGISTRAR JUL 12 1968		25b. REGISTRAR'S SIGNATURE James J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Margaret			First Middle Last Walter			2a. DATE OF DEATH Month July Day 18 Year 1968			2b. HOUR 10P M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 10-8-15			6. AGE (In years last birthday) 52 YRS.		
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel Md.		
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) N. A. H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY A. A.			13c. CITY OR TOWN Brooklyn Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME John Murphy			15. MOTHER'S MAIDEN NAME Unk			13e. STREET AND NUMBER 4611 Ritchie Hwy.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO			17. INFORMANT Family			Address Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY. IMMEDIATE CAUSE (a) CVT 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7/18/68 , 19__, to 7/18/68 , 19__, that (I) (we) last saw the deceased alive on 7/18/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. B. Rammie			DEGREE MD			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 7/19/68		
22d. PHYSICIAN'S NAME (Type) J. B. Rammie MD			22e. ADDRESS 3927 Annapolis Rd Baltimore 27 328 Hospital Drive GB - Md								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7/23/68			23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem			23d. LOCATION (City or Town) (County) (State) AA Co Md		
24. FUNERAL DIRECTOR Mc Culley F. H. 237 Fataurus Ave			ADDRESS 2422 S			25a. REC'D BY REGISTRAR JUL 22 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

1

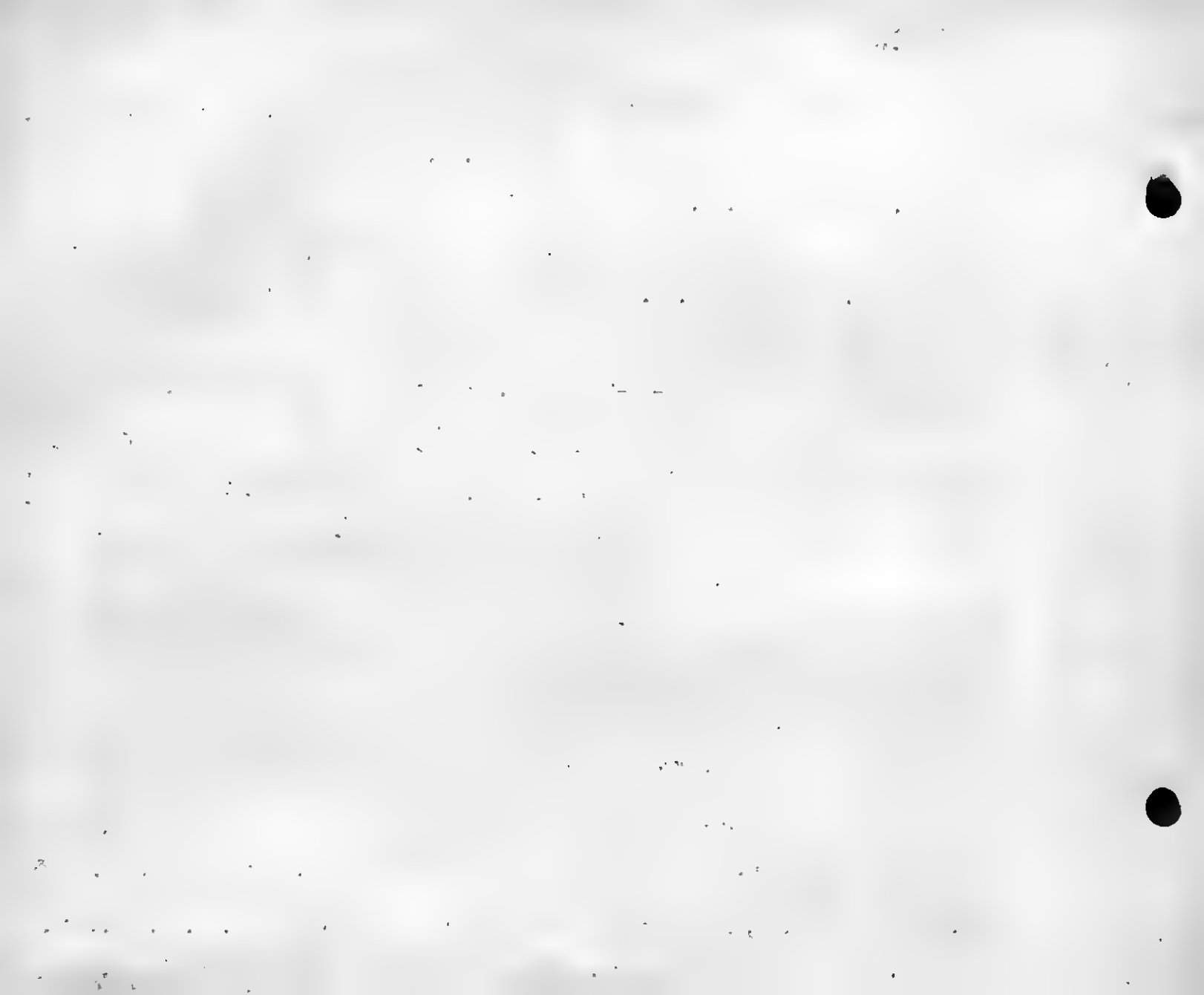
00470

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00478

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Tivis			First Middle Last McKinley Ward			2a. DATE OF DEATH Month Day Year July 31, 1968			2b. HOUR 8P. M			
3 SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 4, 1897			6. AGE (In years last birthday) 70		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS HOURS MIN. YRS.	
7a. BIRTHPLACE (State or foreign country) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel						
10. CITY OR TOWN OF DEATH Glen Burnie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1323 Gatwick Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Coal Miner			12b. KIND OF BUSINESS OR INDUSTRY Mining			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY A. A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1323 Gatwick Road			
14 FATHER'S NAME First Middle Last Rufus Ward				15 MOTHER'S MAIDEN NAME First Middle Last Malinda Cole								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO 232-16-5076		17 INFORMANT Address Mr. Donald Ward 141 Carroll Rd. Glen Burnie						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) Cancer of lung with Metastases DUE TO, OR AS A CONSEQUENCE OF (c) Chronic bronchitis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours 8 months 18 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema												
19a. DATE OF OPERATION 12-18-67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Same as # 18 b				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N. A.				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) N. A.								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) N. A.		21f. LOCATION Street or R.F.D. No. City or Town County State N. A.								
22a. I certify that (I) (this hospital) attended the deceased from May, 1962 , to 31 July, 1968 , that (I) (we) last saw the deceased alive on 30 July, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Hubert F. Manuzak M.D.						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED August 1, 1968		
22d. PHYSICIAN'S NAME (Type) Hubert F. Manuzak						22e. ADDRESS 425 Ritchie Hwy. Glen Burnie, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Ritchie Hwy. A. A. Co., Md.						
24. FUNERAL DIRECTOR George J. Gonce				ADDRESS 4001 Ritchie Hwy. (21225)		25a. REC'D BY REGISTRAR AUG 6 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

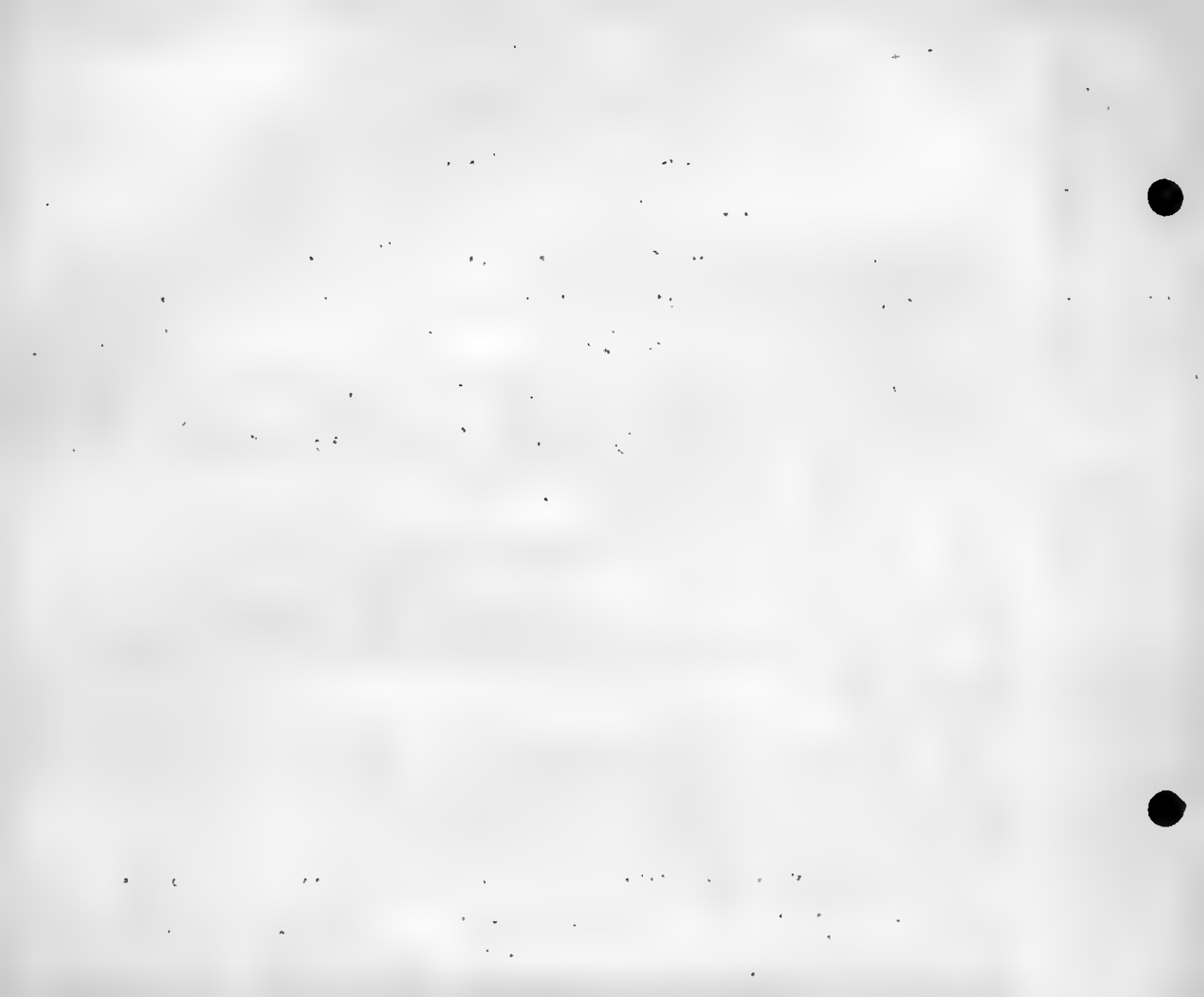
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09471

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09479

1. DECEASED-NAME (Type or print) First Middle Last Frank L. WARFIELD			2a. DATE OF DEATH Month Day Year July 6 1968		2b. HOUR 10:50
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 7, 1887		6. AGE (In years last birthday) 81 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Anne Arundel Md		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Anne Arundel Gen. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ATTORNEY	12b. KIND OF BUSINESS OR INDUSTRY LAW		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER South River Park	
14. FATHER'S NAME First Middle Last MILBURN H. WARFIELD	15. MOTHER'S MAIDEN NAME First Middle Last BELLE Blocksig				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT GRACE G. WARFIELD #13 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HOURS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 7/6 , 1968, to 7/6 , 1968, that (I) (we) last saw the deceased alive on 7/6 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward S. Beck		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22e. ADDRESS 73 Franklin St., Annapolis, Md.		22c. DATE SIGNED 7/9/68	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-10-68	23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE	23d. LOCATION (City or Town) (County) (State) Elkridge Howard Md.	25a. REC'D BY REGISTRAR DATE JUL 12 1968	
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print) John			First Middle Last WEEKS			2a DATE OF DEATH July Month 17 Day 1968 Year			2b HOUR 10:50 P.M.				
3 SEX F		4 RACE N.		5. DATE OF BIRTH 12/25/98			AGE (In years last birthday) 69		IF UNDER 1 YEAR MONTHS 69 DAYS RS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) U.S.A.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Anne Arundel				
10. CITY OR TOWN OF DEATH Crownsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital			12a USUAL OCCUPATION (Kind of work done during last of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY Laborer, P.R.R.				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Baltimore			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 1641 Ashland Ave.	
14. FATHER'S NAME First Middle Last UNKNOWN						15 MOTHER'S MAIDEN NAME First Middle Last UNKNOWN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b SOCIAL SECURITY NO. 217-03-7679A			17 INFORMANT Mrs Marie Butler - 3712 Barrington Rd, Balt.			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Septicemia										1 wk.			
DUE TO, OR AS A CONSEQUENCE OF (b) Urinary Infection										2 wks.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebro-vascular Disease - Thrombosis										-3 wks.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Hypostatic Pneumonia and Anemia.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6/27 , 19 68 , to 7/12 , 19 68 , that (I) (we) last saw the deceased alive on 7/12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE Lionel McHenry Maapp, M.D.			22c. DATE SIGNED 7/12/68			22d. PHYSICIAN'S NAME (Type) Lionel McHenry Maapp, M.D.			22e ADDRESS Crownsville State Hospital, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 7-16-68			23c NAME OF CEMETERY OR CREMATORY Mt. Calvary			23d. LOCATION (City or Town) (County) (State) Anne Arundel County				
24. FUNERAL DIRECTOR Calvin Scruggs			ADDRESS E. Preston St			25a REC'D BY REGISTRAR JUL 15 1968			25b REGISTRAR'S SIGNATURE J. Charles Jr.				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1481
00473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print) <i>LARRY E. WILLIAMS</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> Month <i>7</i> Day <i>13</i> Year <i>68</i>			2b. HOUR <i>11</i> AM				
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>1/11/44</i>	6 AGE (In years last birthday) <i>24</i> YRS	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS HOURS <i></i> MIN. <i></i>	2c. DATE PRONOUNCED DEAD Month <i>7</i> Day <i>13</i> Year <i>68</i>		2d. HOUR <i>11</i> AM		
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CIT ZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Anne Arundel General</i>				
10. CITY OR TOWN OF DEATH <i>GEN BURNIE</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>DC-H-NORTH ARUNDEL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>LABORER</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>7035 Bond St.</i>			
14. FATHER'S NAME First <i>FREDERICK H. WILLIAM</i> Middle <i></i> Last <i></i>					15. MOTHER'S MAIDEN NAME First <i>LOISE</i> Middle <i>ENNIS</i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>357-36-9646</i>		17 INFORMANT <i>PEGGY WILLIAMS</i>			ADDRESS <i>7035 Bond St.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>DROWNING</i> <i>1100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1100</i>										
19a. DATE OF OPERATION <i>7/13/68</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>HOBBY</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <i>MOON P.M. 7/13 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Swimming - Mt. Pleasant Beach.</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Mt. Pleasant Beach</i>			21f. LOCATION Street or R.F.D. No. <i>PASADENA</i>		City or Town <i>PASADENA</i>		County <i>AACO</i>	State <i>MD</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>E. Linhart</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>7-13-68</i>	
EXAMINER'S NAME (Type) <i>E. Linhart</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <i>AACO</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>7/14/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HOLY REDEMPTION CEM.</i>			23d. LOCATION (City or Town) <i>BALTO. MD.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>B. DABROWSKI 2816 E. BALTIMORE ST.</i>					25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
					DATE <i>JUL 17 1968</i>					

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CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Mary</i> First <i>M</i> Middle <i>WILLIAMS</i> Last			2a DATE OF DEATH Month <i>July</i> Day <i>20</i> Year <i>1968</i>			2b. HOUR <i>7:45</i> M	
3 SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>— — 1892</i>		6 AGE (In years last birthday) <i>76</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Anne Arundel</i> Md.	
10. CITY OR TOWN OF DEATH <i>Crownsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Crownsville State Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution, Res. dence before death) <i>207 S. Elwood Ave. Baltimore</i>		13b COUNTY <i>Baltimore</i>		13c INSIDE CITY LIM TSP? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>207 S. Elwood Ave.</i>	
14 FATHER'S NAME First <i>Benjamin</i> Middle <i>—</i> Last <i>SOMMERS</i>			15 MOTHER'S MAIDEN NAME First <i>Amelia</i> Middle <i>Wiley</i> Last <i>SOMMERS</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO <i>213-10-1656</i>		17. INFORMANT <i>Hospital Records — Crownsville State Hospital</i> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hyperpyrexia</i> <i>437.7</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>334 X</i> (b) <i>Dehydration and Inanition.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral and Generalized Arteriosclerosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypostatic Pneumonia — Chronic Brain Syndrome due to Arteriosclerosis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION, Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/19/65</i> , 19 <i>65</i> , to <i>7/20/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7/20/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>Lone Mapp</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>7/20/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Lone Mapp M.D.</i>		22e. ADDRESS <i>Crownsville State Hospital Md.</i>					
23a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		23b. DATE <i>7-22-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR <i>Lilly & Zeiler Inc. 1901-07 Eastern Ave.</i>				25a. RECEIVED BY REGISTRAR <i>UL 22 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

79483

1 DECEASED NAME (Type or print) <u>SHERLEY F. WILLIAMS</u>			2a DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>68</u>			2b HOUR <u>P</u> M	
3 SEX <u>Male</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>Feb 5/1886</u>		6 AGE (In years last birthday) <u>82</u> YRS.	
7a BIRTHPLACE (State or foreign country) <u>Ky</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Anne Arundel</u> Md	
10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Bay Manor Nursing Home</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Civil Service</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md</u>		13b COUNTY <u>Anne Arundel</u>		13c CITY OR TOWN <u>Annapolis</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER <u>RT 2 Box 257</u>		13f CITY OR TOWN <u>Annapolis</u>		13g STATE <u>Md</u>		13h ZIP CODE <u>21061</u>	
14. FATHER'S NAME First Middle Last <u>John R. Williams</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Sarah M. Buckhey</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/>			16b SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mrs. Joseph W. Grimes #3</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocarditis, Right lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia, Generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>4</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u> <u>hours</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis - Moderate back stiffness</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> , 19 <u>68</u> , to <u>7/2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Max C. Frank MD</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>7/2/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>		22e ADDRESS <u>2425 SE Ritchie Hwy - Glen Burnie MD 21061</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7-5-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE LAWN MEM. PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>TERRE HAUTE IND.</u>	
24. FUNERAL DIRECTOR <u>John M. L. Lorton</u>				25a. REC'D BY REGISTRAR <u>JUL - 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00476											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Walter			J		Wilmoth	7 Month 29 Day 68 Year		1 P M			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR			
m		w		6-20-01		67 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. Virginia		U S A				Anne Anundel Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Blen Buena		Beth Anundel Conv. Center		Minister-Retired							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
md.					Balt.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		968 Stoll St 21225		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Marion Wilmoth						Mattie Wilfong					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No						Mrs. Dorothea Wilmoth			968 Stoll St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute MI</u>											
4109 DUE TO, OR AS A CONSEQUENCE OF <u>ASCVD.</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Cerebrovascular Ischemia with convulsions											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-20, 1968</u> , to <u>6-29, 1968</u> , that (I) (we) last saw the deceased alive on <u>7-23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d.) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>E.H. Weiss</u>										7-29-68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
E.H. Weiss, M.D.						615 Hammonds Lane - Balt - 21225					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		8 1 68		Cedar Hill		Brooklyn, A. A. Co. Md.					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mc Cully						130 W. Fort Ave		JUL 31 1968		Charles Judge	

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referred to him with reference
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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9.05 PM

1. DECEASED NAME (Type or print)		First Alpha	Middle D.	Last Woodard	2a. DATE OF DEATH July 4 Month Day 1968		2b. HOUR 8 M
3. SEX Female	4. RACE White		5. DATE OF BIRTH 04-06-22 1889		6. AGE (In years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) XXXXXX VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North Arundel Hospital		12a. USUAL OCCUPATION (Kind of work done during last 12 months, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Bill		First Middle Last Day		15. MOTHER'S MAIDEN NAME First Middle Last (unknown) Mitchell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		(If yes give war or dates of service) None		16b. SOCIAL SECURITY NO. 230-10-1976-D		17. INFORMANT Address Same as #13 Mrs. Hazel Mitchell (daughter)	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Multiple emboli - Lung - femoral</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD-</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 <u>Abtrial tachycardia -</u>							
19a. DATE OF OPERATION 7/4/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED L Femoral emboli		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/22/68</u> , 19 <u>68</u> , to <u>7/4/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/4/68</u> , 19 <u>68</u> , and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE J.B. Ramir		DEGREE J.B. RAMIR MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/4/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 3927 ANNAPOLIS RD Balto 27 Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 7, 1968		23c. NAME OF CEMETERY OR CREMATORY Cooper Cemetery		23d. LOCATION (City or Town) (County) (State) Pennington Gap Va.	
24. FUNERAL DIRECTOR Singleton Funeral Home		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Annie Elizabeth Young			2a. DATE OF DEATH Month 7 Day 7 Year 68			2b. HOUR 8:00p M				
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 2/4/06		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md.				
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Crownsville State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unknown			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1209 Nolan Court Apt. A1	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 493X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic alcoholism										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 6/18 , 19 68 , to 7/7 , 19 68 , that (I) (we) last saw the deceased alive on 7/7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles R. Venter, M.D.				22c. DATE SIGNED 7/8/68		22d. PHYSICIAN'S NAME (Type) Charles R. Venter, M.D.				
22e. ADDRESS Crownsville State Hospital, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/12/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City or Town) (County) (State) Baltimore MD				
24. FUNERAL DIRECTOR 1712 W. North Avenue				25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or print)			First Louis			Middle Joseph			Last ZINDEL			2a. DATE OF DEATH July Month 6, Day 1968.			2b. HOUR 7:55 M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH JUNE 27 1891			6. AGE (In years last birthday) 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Anne Arundel County Md.								
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ANNE ARUNDEL GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SUPERVISOR			12b. KIND OF BUSINESS OR INDUSTRY GENERAL CARPENTER								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY B.A.			13c. CITY OR TOWN Pasadena			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 7876 West Givenside Drive					
14. FATHER'S NAME First George			Middle ZINDEL			Last ZINDEL			15. MOTHER'S MAIDEN NAME First Mary			Middle KASTNER			Last KASTNER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 138 07 37			17. INFORMANT Miss Eileen Zindel			Address Pasadena M.D.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Carcinomatosis												Mos.					
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) Carcinoma of Rectum												2 yrs.					
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
1548																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County			State		
22a. I certify that (I) (this hospital) attended the deceased from 4/26/1968 to 7/4/1968 that (I) (we) last saw the deceased alive on 7/4/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE J. Fred Hawkins, Jr.						DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE, SIGNED 7/5/68					
22d. PHYSICIAN'S NAME (Type) J. Fred Hawkins, Jr.						22e. ADDRESS 16 Murray Avenue, Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE July 10 1968			23c. NAME OF CEMETERY OR CREMATORY GLENHAVEN MEMORIAL PARK			23d. LOCATION (City or Town) Bowie Md.			(County) B.A.			(State) MD		
24. FUNERAL DIRECTOR James D. Bence 410 Ritchie Hwy 25						25a. REC'D BY REGISTRAR DATE JUL 12 1968			25b. REGISTRAR'S SIGNATURE								

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